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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

JANUARY 2000 VOL. 93, NO. 1

EDITORIAL
It's Not Our Fault 3
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE
New Work for the New Year 5
BOYD O. WHITLOCK, MD, TULSA

SPECIAL
OSMA Launches Physicians' Campaign for a Healthier Oklahoma 7
ROBERT J. WEEDN, MD, DUNCAN

SCIENTIFIC
A Cardiac Patient with Renal Failure: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine 11
LEROY SOUTHMAYD, MD, OKLAHOMA CITY; BOB G. EATON, MD, OKLAHOMA CITY; CHRIS KAUFMAN, MD, OKLAHOMA CITY; FRED G. SILVA, MD, OKLAHOMA CITY

SCIENTIFIC
Immunization Rate Comparison for Oklahoma Medicaid Managed Care Population by Age Two: 1995-1998 20
JAMES S. MILLAR, MD, OKLAHOMA CITY; DARENDIA MCCAULEY, PHD, OKLAHOMA CITY; LYNN MITCHELL, MD, MPH, OKLAHOMA CITY; TERRY WINSTON, MA, OKLAHOMA CITY; CHERYL HAYS, RRA, OKLAHOMA CITY

SCIENTIFIC
Severe Invasive Group A Beta-Hemolytic Streptococcus Infection Complicating Pharyngitis: A Case Report and Discussion 25
BLAKE KELLY, MD, OKLAHOMA CITY; LEW DICK, MD, MPH, OKLAHOMA CITY

NEWS
OSMA Delgates Attend AMA Meeting, 29...Brandt to be Honored at "Evening of Excellence," 29...Member Services Seminar Schedule, 30 ...CDC Calls for Prevention Measures for Patients with Diabetes, 31

DEPARTMENTS
Classifieds, 31...Deaths, 34...In Memoriam, 34....CME, 35... Alliance, 39...The Last Word, 40

ABOUT THE COVER
The OSMA's Physicians' Campaign for a Healthier Oklahoma is being launched this month to promote healthier lifestyles and better health for all Oklahomans.



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It's Not Our Fault...

The facts have been gathered and the statistics are quite austere. The citizens of Oklahoma enjoy a miserable report card when it comes to markers of the "public" health. If you take the time to review the statistics **(http://www.health.state.ok.us/board/state/index.html)**, they will cause your heart to sink. We practice medicine in a time where quality is advocated at every turn, where our Board of Medical Licensure takes great pride in the fact that we "discipline" more physicians per capita than any other state in the country...

And still the state of Oklahoma's health is miserable.

It is often easier in our profession to point the finger of blame, distracting each other from the real burden. The burden seems broad enough that several groups could bear it. There is the legislature, the governor, the sad economy, the Health Care Authority, the Oklahoma State Department of Health and all of those mid-level providers that we call "doctor wannabe's." Please don't leave out the lawyers and the crisis that "they" have created around the medical liability issue. We don't trust or accept the guidelines of the federal government. We need to decrease taxes and increase Oklahoma's share of the federal pie. Then there is the miserable rate at which preventive services are covered by the third-party payors.

Did I cover most of the obvious contenders for the blame cycle?

The overarching fact is that most physicians in this state will glance at the data, will possibly hear the medical society talk on the *State of the State's Health*, or will see the blurb in the *Journal* or the OSMA newsletter and consider this as someone else's problem.

You will miss the fact that a national report annually ranks the health status of all states. This report demonstrated that only Oklahoma experienced a decline in health status since 1990, dropping from 27th in 1990 to 44th in 1997, when compared to all other states. Lots of reasons were given: increases in infectious diseases, a reduced high school graduation rate, lower coverage of health insurance, increase in violent crime rates, high smoking/tobacco use rates, and reduced support for public health care. Only Arkansas and Oklahoma experienced an increased total mortality during this time.

The problem with statistics is that they have minimal impact on most physicians. We are used to dealing with this type of reporting. I can rationalize it away, in that I must practice better medicine than that. I am sure that my personal statistics are better than those; I am sure that I am at the 95th percentile.

The statistics are not staring you in the face on a day-to-day basis. The statistics are not looking to you for health information on diabetes or seeking the motivation to start an exercise plan or a weight reduction diet. The statistics are not seeking a health care provider who knows the questions that need to be asked, rather than answering the questions that are asked. The statistics are not taking an opportunity to speak with the basketball-playing adolescent about drug abuse, nicotine addiction, or seatbelt use. The statistics are not intervening in domestic abuse.

The interventions are initiated by you and by me. These interventions are one human being to another human being, one step, one intervention at a time. It is an age-old process, part of the medical tradition...is it failing us now when we need it the most?

This edition of the Journal contains the introductory article of the Physician's Campaign for a Healthier Oklahoma. This is a collaborative effort between your medical association and the Oklahoma State Department of Health. The problem with this type of collaboration is that it is not going to make a difference for the citizens of Oklahoma unless the interventions are put into your clinical practice.

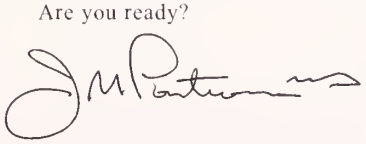
Now is not the time for theoretical evaluation. Now is not the time for worrying about the latest funding stream to pay for this type of intervention. Now is not the time to put prevention into practice, one patient at a time.

Now is the time to intervene in your practice, your little corner of the medical world. It is only with this type of "across the board" intervention that the physicians of this state can make a difference. Making excuses or ignoring the problem will not make the problem vanish. Pointing your fingers at others will not change the future for the citizens of this state.

The Physician's Campaign for a Healthier Oklahoma will give you the place to start. Most of these articles and interventions are reviews of previously-available interventions. Much of it is common sense. But then, if it is that easy, why do we find ourselves in the public health dilemma that currently exists? In reality, it takes an attitude change on the part of physicians.

It is time to act.

Are you ready?



J. Michael Pontious, MD
Editor-in-Chief

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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President's Page

New Work for the New Year

Welcome to the year 2000! All of us at the OSMA are working hard to be proactive and do all those things we think you, our members, want and need for us to do. At our November Board meeting, your Trustees voted to make some aggressive changes in the areas of finance, investments, and budget planning. By now you should have received a letter from the Board Chairman and myself outlining those actions. Over the next few months you will be receiving further information by way of the Journal and newsletter. We want to be sure that you understand why these actions are necessary if we are to continue to be an organization that is effective in meeting its members' needs. We want everyone to feel that membership in the OSMA is truly a benefit.



Members want us to be active in efforts to improve the health of all Oklahomans. OSMA members are asking their association to help them in the areas of legislation—particularly as a physician's advocate in problems related to insurance, Medicare, Medicaid, and managed care—and to become more involved in offering continuing medical education. Members also want us to be active in communications and public relations. Starting now, and continuing in the February and March issues of the Journal, I will try to outline what we are currently doing in these areas, as well as our future plans. I want you to feel that the OSMA is truly a cost-effective organization. I want all of you to help us convince those doctors who are not members that membership in the OSMA is a good thing.

As you are all aware, the State of the State's Health report a couple of years ago showed that the citizens of Oklahoma (our patients) rank poorly in many areas when compared with other states. When we look at our percentage of smokers, number of teen pregnancies, incidence of cardiovascular disease, rate of accidental injuries, etc., etc., we do not look very good.

Through the Council on Public and Mental Health, the OSMA has established the Physicians' Campaign for a Healthier Oklahoma (PCHO). This special task force will be working with physicians' offices to supply appropriate educational materials and patient pamphlets. Task force members will work through county medical societies (we are in the process of visiting 20+ county medical societies throughout the state to let physicians know about the campaign and how they can help, and to let them know what the OSMA is doing in this and other areas). With help from our Public Relations and Professional Communications Councils, the PCHO Task Force will work to educate the public about the state's health status and what they can do to help improve their own health. This is a big job and one that will continue through the next several years. We need participation from all of you.

At the August Board meeting, your Board of Trustees voted to make anti-smoking efforts our number one legislative priority. The PCHO Task Force is working with the legislative council to convince our legislature to spend the tobacco settlement money properly and to establish anti-smoking programs in the state. We are working (in association with the Oklahoma Osteopathic Association, the Oklahoma Hospital Association, and many others) through the Tobacco-Free Oklahoma Coalition to decrease the major hazards of smoking.

These are just a few examples of how your association is working to carry out our number one goal: to be more active in promoting and improving the health of all Oklahomans. Next month I will discuss further details regarding other activities of your association and what plans are for the future. If you have questions or suggestions regarding any of the above, do not hesitate to call me, Dr. David Russell, or Brian Foy.

Boyd O. Whitlock MD.

Boyd O. Whitlock, MD
OSMA President

"These are just a few examples of how your association is working to carry out our number one goal: to be more active in promoting and improving the health of all Oklahomans."

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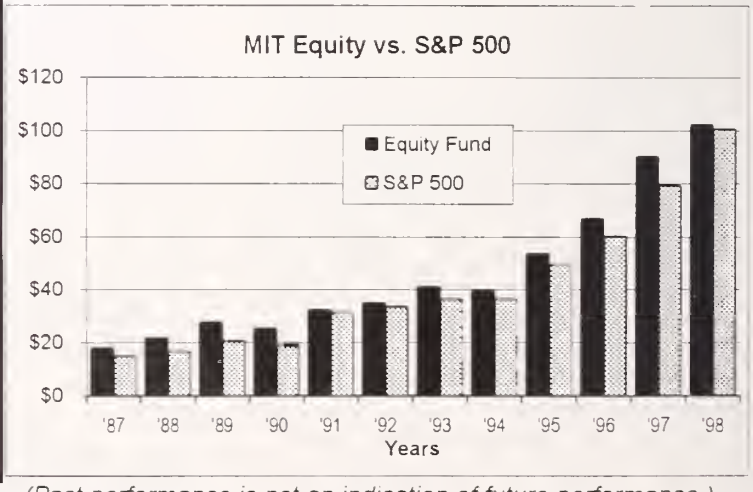
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OSMA Launches Physicians' Campaign for a Healthier Oklahoma

Robert J. Weedn, MD, FACS

In 1997 the Oklahoma State Medical Association Long Range Planning Council extensively reviewed and recommended modifying the organization's mission statement and its goals as follows:

> ***The OSMA's mission is to promote the best health for the people of Oklahoma in a professional, ethical, and compassionate manner by advocating for patients, representing physicians, and promoting the art and science of medicine.***

The first goal of the OSMA Long Range Plan is to assume a more active and visible role in promoting health education. The Long Range Planning Council's action was subsequently approved by the Board of Trustees and the House of Delegates at the 1999 annual meeting. It was clear that an action plan was needed to implement the OSMA mission statement and its number one goal. From this action plan grew the concept of a "campaign for health."

As the practice of medicine continues to evolve, physicians are facing many changes. One of the paradigms for future medical care will be a greater focus on prevention and self care. Media attention to health issues along with the estimated public expenditure of more dollars on non-traditional health care (i.e., complementary and alternative medicine) compared to traditional health care expenditures provide clear evidence of the changing attitudes of our patients. Today, the public expects physicians to be teachers, and it is clear that patients are demanding more information about wellness. Although terribly distorted by the insurance industry, the Health Maintenance Organization concept was originally conceived to emphasize wellness and has helped bring a greater focus on prevention and self-care.

It has become increasingly clear that the vast majority of illnesses in our society are preventable and related to patient behavior and lifestyle choices. When one looks at the Oklahoma State Board of Health and The State Health Department's *State of the State's Health Report*, presented in 1997, 1998, and 1999, the data reveals quite clearly that unhealthy lifestyles are largely responsible for the increased morbidity and mortality rates in Oklahoma. As shown in Figure 1, the age-adjusted death rate for all causes of deaths in Oklahoma is substantially above that of the United States. Figure 2 indicates that, for the top five causes of death in 1998, Oklahoma ranks significantly higher than the U.S. average for deaths from injury, chronic obstructive pulmonary disease, heart disease, stroke, and cancer.

If we are to accomplish the OSMA's mission, we will need to make a greater effort to teach as well as treat, to prevent as well as heal in our practices. *We must motivate the public and our patients to recognize and take responsibility for their health through lifestyle modification.*

The Physicians' Campaign for a Healthier Oklahoma (PCHO) is a proactive project developed by the OSMA and a task force of its leaders to address these problems. It is intended to help distinguish the OSMA and its physician members as leaders in the health care field who share compassion and concern for their patients and for the public. Following the approval of the concept by the Board of Trustees in January 1999, the members of the PCHO Task Force were appointed (see Table 1).

The Task Force's mission statement is ***"To improve the state of the state's health by changing lifestyles and behavior within our communities."*** The defined goals are:

1) to inform the public and body politic of problems delineated in the *1999 State of the State's Health Report;*
2) to develop a plan to address the state's health problems and to improve the health of Oklahomans; and

Direct correspondence to: Joy Leuthard, OSMA, 601 W. I-44 Service Road, Oklahoma City, OK 73118-6073.

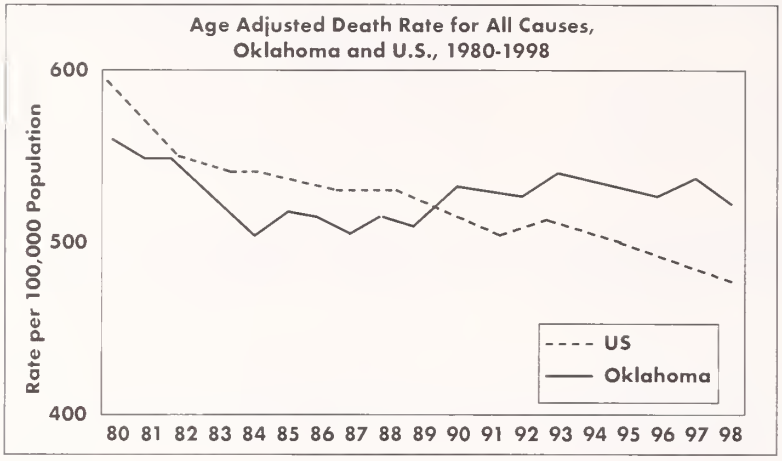


Figure 1.

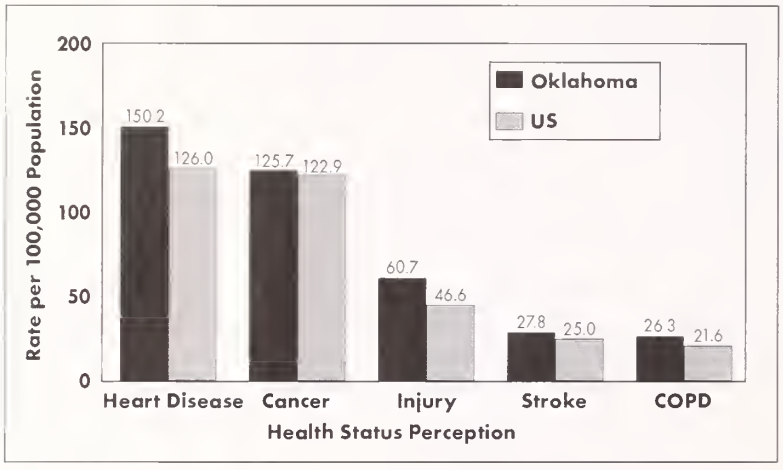


Figure 2.

Table 1. Task Force Membership

- Dr. Robert Weedn, Duncan (Chair), OSMA President Elect
- Dr. Sara Reed DePersia, Oklahoma City (Vice Chair), Deputy Commissioner and State Health Officer, State Health Department
- Dr. Gordon Deckert, Oklahoma City, David Ross Boyd Professor Emeritus of Psychiatry and Behavioral Sciences, OUHSC
- Dr. Hal Varse, Oklahoma City, Chair, Substance Abuse Subcommittee of the OSMA's Council on Public and Mental Health
- Dr. John Bozalis, Oklahoma City, Vice Speaker, OSMA House of Delegates and Director, Schools for Healthy Lifestyles
- Dr. Kent King, Marlow, Chair, OSMA Ad Hoc Committee on Putting Prevention Into Practice
- Dr. Ed Brandt, Jr., Oklahoma City, Chair, OSMA's Council on State Legislation and Regulation
- Dr. William Oehlert, Oklahoma City, Principal Clinical Coordinator, Oklahoma Foundation for Medical Quality
- Dr. Mary Anne McCaffree, Oklahoma City, OSMA Immediate Past President and Chair, Oklahoma Project Director, Women & Girls, Tobacco & Lung Cancer
- Dr. Gary Strebel, Oklahoma City, OSMA Vice President and Chair, Public Relations Council
- Dr. Boyd Whitlock, Tulsa, OSMA President
- Dr. George Prathra, Tulsa, Former Director, Tulsa County Health Department
- Dr. John Leatherman, Norman, Chair, OSMA Council on Professional Communications
- Dr. David Nierenberg, Tulsa, Chair, OSMA Member Services Council
- Mrs. Cheryl Baker, Edmond, President, OSMA Alliance

Recently, Jeff Sparling, MS-III, and Dr. David Kendrick have been added to the Task Force to represent medical students and resident-in-training physicians, respectively.

3) to emphasize the physician leadership role and responsibility in this process by being proactive and working independently with patients and in collaboration with community leaders and other organizations to improve the health of Oklahomans.

The initial public effort of the Task Force was a media briefing at the State Capitol when the ***1999 State of the State's Health Report*** was released in March. This news conference was designed to bring attention to the Report and was conducted before a standing-room-only crowd.

The Task Force has since delineated five strategic priorities:

1) prevention
2) education
3) coalition-building
4) development of specific programs and services related to these issues
5) evaluation of the effectiveness of the campaign in such a manner as to shape it on a year-to-year basis.

In addition, the Task Force concluded that these five strategic priorities should be addressed in the campaign, as implementation objectives, at three different levels: the physician's office, the community, and at a state level. This will be accomplished by: 1) promoting clinical prevention and wellness education in the physician's office; 2) developing community-oriented initiatives and programs through county medical societies and coalitions within the community; and 3) conducting a statewide public information campaign on behalf of the OSMA.

The OSMA and its member physicians envision the Physicians' Campaign for a Healthier Oklahoma as an ongoing endeavor. The first year of the campaign will have initiatives in all three levels to create awareness of the campaign and its goals among our members, our patients, and the public. Modifications to the campaign are expected as timelines and budgets are approved.

Some of the specifics of the program include patient education materials to be used in the physi-

cian's office to inform and teach patients about healthy lifestyle choices and lifestyle modifications. A brochure is being prepared that outlines the facts about the consequences of unhealthy lifestyle choices. It will feature a risk survey in questionnaire format that can be administered in the practice as a cue for physician intervention. The theme of the brochure and the campaign will be "It's your health, your life...and your choice."

A patient handout entitled *Recommendations for Healthy Living* is included with this article. We hope physicians will photocopy these pages and utilize them as patient education materials.

There is the potential for pilot projects to be developed in Oklahoma that utilize *Put Prevention Into Practice*, a U.S. Public Health Service program. This sort of formal program would encourage systematic record-alerting mechanisms involved in clinical prevention. Another PCHO objective is to alert physicians regarding payment sources for clinical prevention and to develop CME for physicians and other health care professionals in which effective preventive services and health promotion are emphasized

The OSMA also intends to initiate a statewide public information campaign as part of this program. *Journal* articles will be published on prevention services and will be accompanied by patient education materials similar to the one included with this article.

All prevention activities will be supported by a public relations and communications campaign aimed at the media throughout the state. The Oklahoma Medical News Network is a project currently being planned under the auspices of the OSMA's Council on Public Relations. This is a program whereby radio stations can call an 800 number and receive either direct feeds of 60-second health-related spots or can obtain a CD containing these spots to air at no cost to the station.

During the month of November 1999, the campaign was a sponsor for the "Take Care" program conducted by Tulsa's KOTV Channel 6 that reached the eastern part of the state. The program, targeting the elderly, is intended to help save lives by providing important medical information in the form of an EMS file that emergency personnel can easily locate. The EMS file is a large amber vial containing a health questionnaire for listing vital medical information. It is stored inside the participant's refrigerator, and special decals are placed on the front door to alert emergency medical personnel that the information is available. The vial also contains a brochure explaining the Physicians' Campaign for a Healthier Oklahoma. As part of the program, KOTV produced and aired a 30-second public service announcement about the campaign that ran 69 times during the month of November. They also aired a five-part series of health news features that included interviews with OSMA physicians. More than 18,000 vials were distributed throughout northeastern Oklahoma through this project, and a similar program is set for this month in central and western Oklahoma in partnership with KWTV Channel 9 in Oklahoma City.

Other future objectives include initiating legislative action to enhance payment for preventive services, developing financial support for the Physicians' Campaign on an ongoing basis, and supporting activation of the Oklahoma Consortium for Improving the Health of Oklahomans (OCHIO), a statewide collaborative effort. A PowerPoint® presentation has been developed along with speakers' guidelines that can be utilized by clinicians to explain the Physicians' Campaign to interested community groups. A 10-15 minute video presentation is being developed as well. Several 30-minute television programs on various aspects of prevention are also being contemplated for use on public access television stations.

On the community level, the initial efforts will be related to providing presentations for schools, civic clubs, and other groups that focus on the state of the state's health, the Physicians' Campaign for a Healthier Oklahoma, and lifestyle modifications to promote health and wellness. Several community initiatives are being developed, such as the Turning Point project in Cherokee, Texas, and Tulsa Counties and the Schools for Healthy Lifestyles project in Oklahoma County. These represent collaborative projects with local health departments, county medical societies, hospitals, chambers of commerce, civic groups, private businesses, and the faith communities throughout the state.

The Physicians' Campaign for a Healthier Oklahoma is committed to making a difference in the health and, ultimately, in the lives of the people of our state. We must promote and teach our patients about the right choices.

If you'd like more information about the Physicians' Campaign for a Healthier Oklahoma, please contact Joy Lenthard, OSMA's Director of Health Care Policy and Research, at 405/843-9571 or 1-800-522-9452.

The Author

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Recommendations for Healthy Living

The way you live—your lifestyle—is one of the most important factors in determining the state of your health. In order to increase your chances of maintaining good health, you must take care of yourself continually—and that means making good preventive health habits a part of your everyday life. Below are a few reminders—things each of us can do to improve our chances for a longer, healthier life. Please look over these recommendations and make some changes if you need to.

1. Don't smoke or use tobacco in any form.
2. Drink alcohol in moderation, if at all. And if you do drink, don't drive.
3. Eat a healthy diet. Include more fresh fruits, vegetables, and fiber and fewer saturated fats and salt. Drink plenty of water (6-8 glasses per day).
4. Supplement your diet with calcium and vitamins; if you're a woman of childbearing age, add a folic acid supplement.
5. Maintain your ideal weight.
6. Exercise. Try for a minimum of 20 minutes, 3 times a week. And get enough sleep.
7. Wear your seat belt.
8. Make sure you and your family get appropriate immunizations.
9. Don't use addictive drugs.
10. Screen for high blood pressure, diabetes, and cholesterol as well as breast, cervical, prostate and colon cancer according to your sex, age, and family history.
11. Wear sunscreen and avoid getting too much sun.
12. Know your family medical history and your other risk factors for disease.
13. Learn to manage stress. Develop an emotional support system; cultivate relationships with family and friends.

The physicians of Oklahoma are interested in the health of the people of our state. But in the long run, it's up to each individual to make good choices about their health. Because when it's all said and done, ***"It's your health, your life – and your choice."***

On behalf of the Oklahoma State Medical Association's
Physicians' Campaign for a Healthier Oklahoma

We wish you well!

Patient Handout #1

A Cardiac Patient with Renal Failure: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine

LeRoy Southmayd, MD; Bob G. Eoton, MD; Chris Koufmon, MD; Fred G. Silvo, MD

Case Presentation

Leroy Southmayd, MD

A 67-year-old male presented to the emergency room complaining of progressive dyspnea, orthopnea, edema, and decreased urine output. There was no chest pain, urinary discomfort or hematuria.

His past medical history was extensive: hypertension for 30 years, hyperlipidemia, heavy smoking, depression, osteoarthritis, ischemic cardiomyopathy with myocardial infarctions, CABG 12 years previously, congestive heart failure, and peripheral vascular disease with past bilateral carotid endarterectomies and bilateral femoral-popliteal bypass one month previously. Mild chronic renal insufficiency had been noted (BUN 22/Cr 1.5 four months previously and BUN 23/Cr 1.6 two months previously). Benign prostatic hypertrophy was diagnosed four years earlier. One month ago trimethoprim was begun for prostatitis.

His temperature was 96.8°F, the pulse was 76/min and regular, respirations 20/min, blood pressure 184/89 mm/Hg, weight 75.9 kg, and height 5'10".

On physical exam the patient was well developed, alert, and in mild respiratory distress. His eye movements were normal. Jugular venous distention was noted. There were no carotid bruits or adenopathy. His lung exam revealed basilar crackles. There was a regular cardiac rhythm with a II/VI systolic murmur. No gallop or rub was noted. His abdomen had normal bowel sounds, no tenderness, multiple healed scars, a small reducible periumbilical hernia, and no hepatosplenomegaly. There were no abdominal bruits, though bilateral femoral bruits were heard. His extremities showed no edema or ulcers, and absent dorsalis pedis pulses. Rectal exam revealed a 2+ enlargement of the prostate without nodules or tenderness.

Admission laboratory studies showed: glucose 191, Na 136, K 4.4, Cl 103, CO_2 24, albumin 3.5, protein 5.7, calcium 8.4, phosphorus 3.6, cholesterol 121, alkaline phosphatase 60, creatine phosphokinase 71, lactate dehydrogenase 179, AST 29, BUN 34, and Cr 3.0. A urinalysis revealed specific gravity 1.015, pH 5.0, protein 1+, blood 1+, with microscopic showing 0-2 RBC, 0-2 WBC, and no casts. An arterial blood gas showed pH 7.41, pCO_2 37, pO_2 68 on room air. Complete blood count revealed: WBC 12, Hb 11.7, Hct 33.9, MCV 92, and Platelets 242. Protime was 13.1 seconds with INR 1.2.

The electrocardiogram showed sinus rhythm, left axis deviation, right bundle branch block, possible old inferior MI, and non-specific anteriolateral ST-T abnormalities.

The chest radiograph showed generous heart size, no pulmonary engorgement, blunting of the posterior costophrenic angles consistent with effusion, hyperacration consistent with COPD, and atherosclerotic changes of the aorta.

On admission he was treated for congestive heart failure. Diuretics were increased which helped lessen his dyspnea. A myocardial infarction was excluded by serial cardiac enzymes and electrocardiograms. An echocardiogram showed an ejection fraction of 45-50%. There was moderate to severe mitral regurgitation and mild aortic insufficiency.

Serum creatinine rose to 3.0 and renal consultation was obtained. A radionuclide renal

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scan suggested hydronephrosis on the right. The right kidney was 9.2 cm with a 14 cc/min glomerular filtration rate (41% of the total GFR) and the left kidney 11.8 cm with a 22 cc/min filtration (59%). A renal ultrasound showed no hydronephrosis.

Doppler studies of the renal arteries suggested a right-sided stenosis of 60-99% and renal parenchymal disease.

The following test results were normal or negative: urine eosinophils, blood cultures, antinuclear antibody, C3 and C4 complement, antineutrophil cytoplasmic antibody (ANCA), antiglomerular basement membrane antibody. A serum protein electrophoresis showed only a low albumin, and a 24-hour urine contained 1.4 grams of protein. By the time of this timed urine collection, the serum creatinine had further risen to 3.6.

With progressive worsening renal function of unclear cause, a percutaneous renal biopsy was performed.

Question: Was a differential white count obtained from the blood? Is there any description of the skin other than "non-cyanotic"? Were there any petechiae or purple toes?

Answer - Dr. Southmayd: The question about the skin examination is good. On every comment about the feet, including the nursing notes, there was no mention of purple macules or petechiae on the toes.

His white blood cell differential on admission had 60% neutrophils and 8% eosinophils. With a total WBC of 12,000, he had a mild eosinophilia.

Question: Was a urine protein electrophoresis done?

Answer - Dr. Southmayd: No, only the serum protein electrophoresis.

Case Discussion
Bob G. Eaton, MD

Our patient today had several angiograms to demonstrate multiple atherosclerotic problems. In 1992 the left carotid had a large ulcerating plaque at the bifurcation. The right carotid also had severe atherosclerotic disease at the bifurcation. A CT from October of 1993 also shows many arteriosclerotic changes of the abdominal aorta with a small aneurysm just above the bifurcation of the aorta. He has failure of complete rotation of both kidneys, so the renal pelvis is anterior and fairly large on both of them without evidence of obstruction. An angiogram was performed July 30, 1997, a little bit before he came to the hospital in October. An aortogram reveals one renal artery on the right and one renal artery on the left. The right iliac artery is completely occluded. There is an aorto-iliac bypass graft and a lot of arteriosclerotic disease close to the bifurcation of the iliac artery. He has had a femoral-femoral bypass graft. Both kidneys exhibit blunting of the calyces and tiny indentations in the periphery of the kidney. Sometimes the indentations are due to cholesterol emboli or some kind of vasculitis. There is no evidence of micro aneurysms that you might see with vasculitis. Also, we might talk about certain indentations of the periphery of the kidney. If there is an indentation that is pointing to a calyx, most of the time it is due to pyelonephritis with damage to distule tubules and atrophy of the water shed of those tubules. If you have an indentation due to a fairly large embolus the indentation usually is between the calyces. These findings are sometimes helpful as a differential diagnostic point. The patient's chest is not very remarkable. The heart is a little bit big, but certainly there is no evidence of pleural effusion or Kerley B lines or anything to indicate that the patient had chronic congestive heart failure. We have another film later on where the patient has a pacemaker in place. The patient had a coronary artery bypass graft 12 years ago.

Case Discussion
Chris Kaufman, MD

This was an elderly man who presented with symptoms of congestive heart failure and had evidence of severe peripheral vascular disease and mild renal failure. A key issue regarding the renal failure is its duration. Was it acute or chronic? We know that his renal function was stable for two months prior to admission, so sometime in the last two months he had deterioration in renal function. I suspect most of his renal problems occurred in the last month, so I am going to primarily consider the differential diagnosis of acute renal failure. What I would like to do is discuss the way I thought about the mechanisms leading to acute renal failure in this patient. These mechanisms can be classified as pre-renal, post-renal, (obstruction) or intra-renal which implies a structural abnormality; something that we might see for example on a biopsy.

In this case there are some factors that favor a pre-renal explanation and there are some

things against it. The patient presents with symptoms of worsening congestive heart failure so one would have to consider whether congestive heart failure causing renal hypoperfusion is the explanation for the renal insufficiency. However, the clinical features and the radiographic findings do not support a diagnosis of congestive heart failure, which must be quite severe to cause this degree of azotemia (serum creatinine 3.6 mg/dl). Also, the BUN to creatinine ratio was normal, 10 to 1, which is not characteristic of pre-renal azotemia where you usually find a greater increment in BUN compared to creatinine. Another possibility that I considered is bilateral renal artery stenosis. Doppler studies indicated bilateral renal artery disease and suggested that it was severe on one side. Although ultrasound is a crude screening test, in this setting with severe peripheral vascular disease one would have to consider renal artery stenosis as a possible cause of the azotemia. Severe bilateral renal artery stenosis may cause a pre-renal type of azotemia just by limiting renal perfusion. Also, there was some uncertainty about whether the patient was taking an angiotensin converting enzyme (ACE) inhibitor. If he was taking an ACE inhibitor and had bilateral renal artery stenosis, then one could postulate a hemodynamic type of acute renal failure on that basis. I will come back to that possibility before finishing up. He did have relatively benign urine. Just a little bit of protein and a few red blood cells were noted. These findings would fit with pre-renal azotemia but on quantification there was almost 1.5 grams of protein which is too much for "pre-renal" azotemia, and suggests something else going on. Overall I would say that the data does not support a pre-renal mechanism in this case. Be aware, however, of the interaction between an ACE inhibitor and renal artery stenosis, which can result in a hemodynamic type of renal failure resembling "pre-renal azotemia." In the presence of a tight renal artery stenosis where there is hypoperfusion of the kidneys, the compensatory response includes activation of the renin angiotensin system, which increases angiotensin II levels, constricting the postglomerular arteriole to maintain the hydraulic pressure within the glomerular capillaries. With administration of an ACE inhibitor or an AII receptor antagonist the action of angiotensin II is inhibited, the hydraulic pressure within the glomerular capillaries falls and acute renal failure ensues. However, this happens only with a severe stenosis and leads to azotemia only when there is bilateral occlusion or when there is only one functioning kidney with a stenosis. Also, this occurs only in patients who are taking a diuretic (he was taking furosemide). I do not think this is the explanation here because the angiographic findings essentially exclude renal artery stenosis.

Another consideration that we do not want to overlook is obstructive nephropathy. He has a history of prostatic hyperplacid, a benign urine sediment, and a renal scan suggested the possibility of hydronephrosis. However, from what Dr. Eaton has shown us coupled with the ultrasound report, we can be pretty confident that he did not have hydronephrosis; therefore, he probably did not have urinary obstruction. Also, obstruction would have to be bilateral, as bladder outlet obstruction was ruled out. Keep in mind that bilateral ureteral obstruction has been reported as a complication of aorto-iliac bypass grafts due to inflammatory changes at the anastomosis site that is close to where the ureters pass over the pelvic brim. Also, retroperitoneal fibrosis may follow this type of surgery and cause ureteral obstruction.

I believe this man has a renal parenchymal disorder causing his acute renal failure. The possibilities are glomerulonephritis, a tubular interstitial nephropathy, or a vasculopathy. I would like to consider each of these briefly. With regard to glomerulonephritis, he presents with symptoms of worsening heart failure but there seems to be some uncertainty about whether edema was present. The history reports worsening shortness of breath and edema, but the physical exam does not describe edema. Keep in mind that when elderly patients develop acute glomerulonephritis, they often present with symptoms of heart failure. The renal manifestations which are primarily laboratory data may be easily overlooked. Also, glomerulonephritis is relatively uncommon in the older patient. However, a gram and a half proteinuria would be typical for acute glomerulonephritis. Only a few red blood cells were noted, but sometimes in acute glomerulonephritis the urine sediment is relatively scanty. On the other hand, we have no evidence of a recent infection and there is no edema, which are strong points against acute glomerulonephritis. Also, C3 and C4 complement levels were normal; usually C3 will be low for at least four or five weeks after the onset of the illness. Overall, acute glomerulonephritis is an unlikely possibility that cannot be completely excluded. Tubulo-interstitial disease also needs to be considered. I am talking

Table 1. Characteristics of 52 patients with atheroembolic renal failure after invasive procedures

Risk Factors and Medical History	Percentage or Mean ± SD	No. Present/ No. Evaluated
Age (yr)	69 ± 7	59/52
Male	75	39/52
Baseline serum creatinine (μmol/L)*	150 ± 53	49/52
Hypertensian	81	42/52
Current smaker	50	26/52
Hyperchalesteralemia	49	18/37
Diabetes	33	17/52
Caranary artery disease	73	38/52
Peripheral vascular disease	69	35/51
Cerebravascular disease	46	24/52
Abdaminal oorta aneurysm	48	23/48
Anticaogulation	37	19/52
Invasive pracedure		
Coronary angiogram	42	22/52
Corotid ongiogrom	25	13/52
Thoroco-abdominal ongiogrom	19	10/52
Abdaminal angiagrom	10	5/52
Cardiavasular surgery	4	2/52
Sign/symptams within 24 hr		
Neuralagical changes	23	9/39†
Gastraintestinal changes	29	14/49
Cardiavasular surgery	4	2/52
Elevatian in blaad pressure	23	11/48
Cutaneaus findings	21	10/48
Urinalysis		
Hemoturio (>5 RBC/hpf)	41	20/49
Pyurio (>10 WBC/hpf)	29	14/49
Costs (>10/hpf)‡	12	6/49
Prateinuria§	63	31/49

Abbreviations: RBC=red blood cells, hpf=high-powered field; and WBC=white blood cells.
* To convert to mg/dL, divide by 88.4
† Data not available for 8 patients. The 5 patients who underwent abdominal angiograms were excluded because they were not at risk for neurologic sequelae from atheroembolism.
‡ Granular casts in 4 patients, hyaline in 1, and unknown type in 1; no patients had WBC or RBC casts.
§ Proteinuria defined as: dip stick >1 + or >0.3 g/24 hr

Reprinted with permission. Thadhani RI, Camargo CA Jr, Xavier RJ, Fang LST, Bazari H. Atheroembolic Renal Failure after Invasive Procedures. Natural History Based on 52 Histologically Proven Cases. *Medicine* 1995; 74(6):352.

primarily about acute tubulo-interstitial nephritis. There are two varieties. One is the acute tubulo-interstitial nephritis that occurs with non-steroidal anti-inflammatory drugs. We are told that he had not received NSAIDs for three months, which pretty much excludes that possibility. Also, when NSAIDs cause acute renal failure, it is usually associated with nephrotic syndrome due to minimal change disease. The second variety, which is relatively common, is the allergic type of drug induced interstitial nephritis. There is a long list of drugs that can do this. These patients typically present with fever, skin rash, eosinophilia, and acute renal failure. Among the agents that have been incriminated, the most common would probably be sulfa drugs. Dr. Southmayd tells me that this man was taking trimethoprim (TMP) and not trimethoprim-sulfa. If he was taking TMP-sulfa I would be more concerned about acute interstitial nephritis. Ranitidine and furosemide have been reported to cause interstitial nephritis but they are on the long list of rare and not well proven causes. Also, he did not have fever or rash and the mild eosinophilia might tie in with one of the vasculopathies that we are going to discuss in a few minutes. Usually patients with acute interstitial nephritis of the allergic type have quite a few white blood cells in the urine but they may have a pretty benign urine. One would also be interested in a test for eosinophils in the urine. A high eosinophil count in the urine is one of the characteristic laboratory findings in allergic interstitial nephritis. One needs to ask for a Hansel stain of the urine because the results are more accurate than with Wright stain. I would be interested in a urine protein electrophoresis in a patient like this because unexplained renal failure in the elderly may be due to a plasma cell dyscrasia. Overall, I do not believe this patient had acute interstitial nephritis or myeloma kidney, but neither can be completely excluded.

Finally, we come to the vasculopathies to complete the differential diagnosis. There are two major types to consider. One would be an immune-mediated vasculitis involving the kidneys and the other the syndrome of cholesterol crystal embolization. I do not think there is any way to exclude vasculitis in this case. The negative ANCA test is a strong point against it but a systemic vasculitis can occur without ANCA. However, in this patient the clinical setting favors cholesterol crystal embolization over an immune-mediated vasculitis. I am going to talk very briefly about this cholesterol embolization syndrome which is what I think he had. Items in favor of it would include the diffuse atherosclerosis that we have seen. He had a recent femoral-popliteal bypass. There would not be much opportunity for embolization from surgery but it was preceded by an angiogram, and that included running a catheter above the renal arteries. He was on warfarin therapy, which has been associated with cholesterol embolization. His blood pressure was high, but we do not know his usual blood pressure. A recent worsening of his blood pressure is a common finding in any vasculopathy. The renal doppler study results reported an increased "end-diastolic ratio." This finding may be akin

to a high resistive index, which is a measure of renal vascular resistance. A high intra-renal vascular resistance may occur with a small vessel vasculopathy due to cholesterol embolization. I want to finish up by pointing out some of the key features of cholesterol embolization syndrome so that you can see that he has many of these findings. Table 1 is from a review of 52 cases at the Massachusetts General Hospital published in the journal *Medicine* by Dr. R. Thadhani in 1995. The article reviewed all of their cases collected over a decade with cholesterol embolization associated with invasive procedures and causing acute renal failure. The procedures were primarily angiograms but also included vascular surgery. I would imagine that most patients having vascular surgery also had angiograms done in preparation for the surgery. The table lists the demographic and clinical features of these patients.

You can see they were elderly and mostly men. All were white and 90% had been smokers at one time or another. Hypercholesterolemia, diabetes, and coronary disease were common. The signs and symptoms included neurologic symptoms if the aortic arch was the source of the embolization. Gastrointestinal symptoms from bowel ischemia or pancreatitis were common. Cardiovascular symptoms, including a rise in blood pressure were commonly noted. Cutaneous findings were found in only 10 of 48 in the first 24 hours, but in the first month about 50% of the patients had some skin findings. So, although the cutaneous findings are relatively common, there are still 50% of the cases where no clues arise from looking at the skin. These patients will often have micro-hematuria, but many do not, and proteinuria tends to be mild or absent. A 14% incidence of eosinophilia was noted in this series. Probably one needs to measure the eosinophil count early in the course of the illness and check it several times to pick up the "characteristic" increase in eosinophil count which has been reported with cholesterol embolization. The presence of eosinophilia is one of the reasons that cholesterol embolization may mimic systemic vasculitis.

In summary, I think that cholesterol embolization syndrome is the most likely diagnosis in the patient, but I cannot rule out interstitial nephritis, glomerulonephritis, or even myeloma cast nephropathy.

Question: What is the mechanism of the renal failure from cholesterol embolization?

Answer: It is curious that cholesterol embolization may occur in one shower and yet the renal failure is delayed and then progresses even though there may be no evidence of continued embolization. Histologically, you often see an inflammatory reaction and thrombosis, which probably occur late. Probably there is a late inflammatory reaction and thrombosis leading to patchy ischemia.

Question: Given that his creatinine was elevated previously do you think that there is also another problem going on?

Answer: The baseline serum creatinine was only slightly elevated (1.8 mg/dl). This was probably due to hypertensive vascular disease. However, there are cases where cholesterol embolization occurs spontaneously, without any preceding events, so this process may have begun months earlier.

Question: Dr. Tom Whitsett: It seemed that the arteriogram, on the right side particularly, was discrepant with the ultrasound size on that side, suggesting impaired vascularization of the periphery on that side a couple of months before the patient presented and that would not be inconsistent with the previous problems in that terminal vasculature either on a hypertensive or an embolic basis.

Answer: I agree. There is angiographic evidence that he had small emboli to the kidney prior to the last angiogram. One thing that I did not point out is that the small size of the right kidney is probably due to an occluded accessory renal artery because the main renal arteries are OK, but the whole inferior pole of the right kidney is completely atrophied. This was probably due to an old occlusion of an accessory renal artery or perhaps a branch of the main renal artery.

Discussion

Fred Silva, MD

The renal biopsy was adequate. Three studies were performed: light, electron, and immunofluorescent microscopy. Light microscopy showed renal cortex only (Figure 1). There were 14 glomeruli present; five of those were globally sclerotic. The nine patent glomeruli were normal in size and cellularity. The capillary walls appeared thin and delicate. There were no crescents. As I mentioned, about a third of the glomeruli were globally sclerotic. Studies from

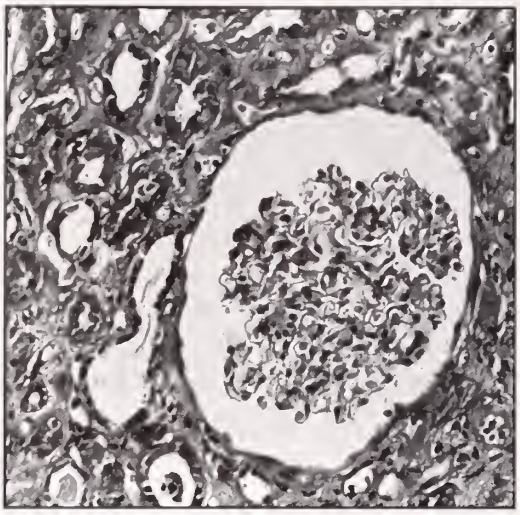


Figure 1. Renal biopsy. Trichrome stained sections show essentially normal appearing glomeruli. There is diffuse tubular atrophy and interstitial fibrosis. Note the thick-walled renal artery in the corner.

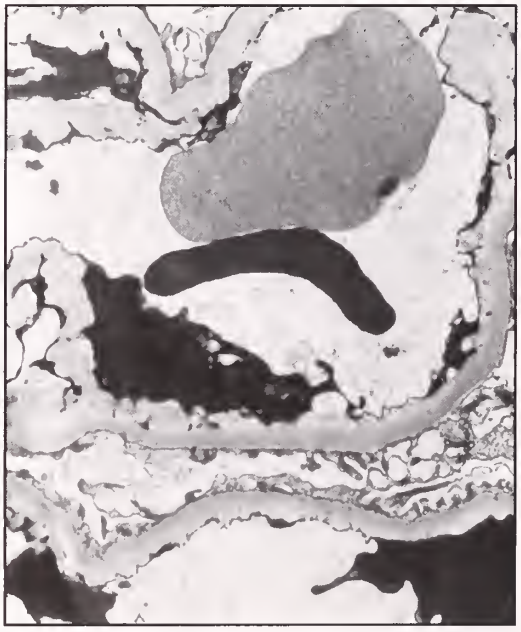


Figure 2. Electronmicrograph showing a segment of the glomerulus. There is mild thickening of the glomerular basement membrane and wrinkling of the glomerular basement membrane over the mesangial regions. This is most consistent with vascular disease. No discrete "immune-type" deposits are identified.

the Manhattan Medical Examiners Office have shown that in people dying violent deaths in New York under the age of 40 one is allowed up to 10% of the glomeruli to be globally sclerotic. Over the age of 40 there is so much vascular variability from person to person it is hard to know what the normal percentage of globally sclerotic glomeruli should be. There was some significant tubular atrophy and interstitial fibrosis in this biopsy. There was no evidence of interstitial inflammation or eosinophils, so there really was no evidence of a primary glomerulonephritis nor was there evidence of a primary interstitial nephritis. There was evidence of severe vascular disease with thickening of the vessel walls of several interlobular arteries. Thus, the diagnosis at this state was an arteriolar- and arteriolo-nephrosclerosis. The "nephro" meaning that the severe vascular disease, which in this patient was probably due to hypertension, was affecting the renal cortex in terms of interstitial fibrosis and tubular atrophy. There were slightly torturous vessels cut across several times. There was no evidence of vasculitis. By electronmicroscopy we had six glomeruli and two globally sclerotic glomeruli to study. We want to study the non-globally sclerotic glomeruli because sclerotic glomeruli are nothing but "tombstones" and you cannot tell anything diagnostic from those. The non-sclerotic glomeruli were largely unremarkable (Figure 2). There was no evidence of any "immune-type" electron dense discrete deposits. There was increased mesangial matrix, a little wrinkling of the glomerular basement membranes (GBM) where it crossed over the mesangium, and a little thickening of the GBM's. Those changes are just evidence of vascular disease. We did direct immunofluoresce and it contained three glomeruli. They were completely negative. There was no evidence of immune deposits anywhere. Thus, all we noted so far was long-term vascular disease, probably related to hypertension.

One of the things that my ex-renal fellow, Dr. Zoltan Laszik (now an attending at OU), suggested that we ought to do is to polarize the material for immunofluorescence microscopy. We did and in one piece of the 1×2 ml section of snap frozen tissue we saw some crystals that were birefringence (Figure 3). These spicules of cholesterol emboli were noted in a renal subarcuate artery. Cholesterol emboli may be difficult to see by light microscopy because the processing of the renal biopsy dissolves the cholesterol emboli. They may be also quite focal and difficult to recognize. The snap frozen tissue you use for immunofluorescence may contain visible cholesterol emboli after polarization. We went back to the light microscopy and found in retrospect one focus of cholesterol emboli; the cleft-like area in the vessel was really sugges-



Figure 3. Fluorescence microscopy. This unstained snap-frozen piece of renal tissue in preparation for Immunofluorescence was polarized. Numerous sharp-ended cholesterol crystals are noted after polarization microscopy.

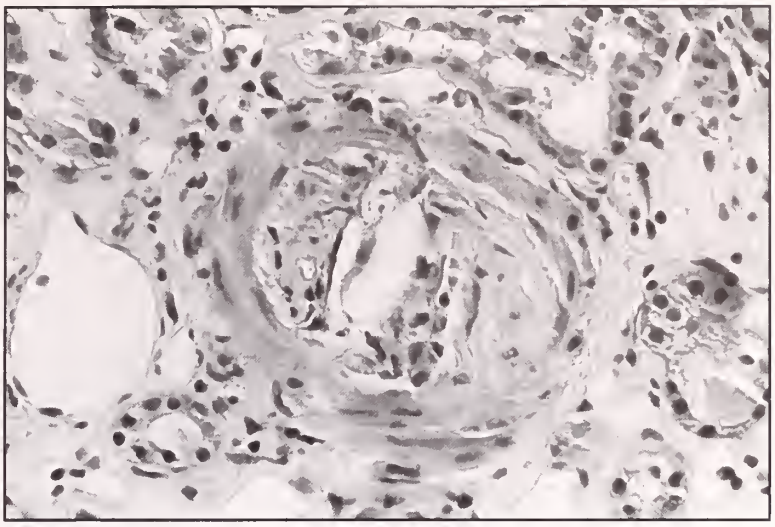


Figure 4. Renal biopsy. Other sections showed an artery with a jagged lumen suggestive of cholesterol embolization. The cholesterol clefts are dissolved by the process used for the preparation of the standard light microscopic sections.

tive of a cholesterol embolus (Figure 4). We looked at the distribution of the arteries in our small renal biopsy, and we did not have any arcuate vessels but we did have one sub-arcuate in the three tissues (LM, EM, IF) and it had the cholesterol embolus I showed you, by polarization microscopy. We had a total of seven interlobular arteries and one of those seven had cholesterol embolus; we did not see any cholesterol emboli in the afferent artery or in the glomeruli.

If you look at a renal functional study called the reciprocal of the serum creatinine, many nephrologists have talked about the importance of this as a "tracker" of disease. Although each renal patient is going to have a slightly different line in terms of the angle, for any patient with renal disease, in general they pursue a straight-line course if you plot reciprocal of the serum creatinine over time. We had four points on this patient that we could plot (Table 2). This is often used to predict who is going to be going to dialysis and at what time. Our patient did not pursue a straight-line course (Table 2). Something additional seemed to happen to his renal function between two months prior to admission (PTA) and his admission. I believe that this altered angle indicates that some additional insult has been superimposed upon the arterial- and arteriolo-nephrosclerosis. It is most likely one or more cholesterol embolizations.

The last bit of information that I would use to suggest that these cholesterol emboli are meaningful findings to the patient's clinical course is to look at the biopsy that we received and ask

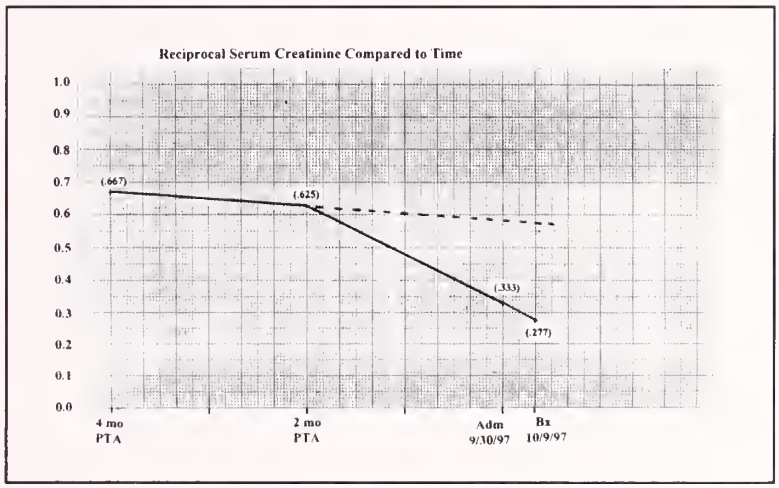


Table 2. The reciprocal of the serum creatinine over time. Note the break in the straight-line expected. This suggests that there was an acute and/or additional insult superimposed upon the steady slow progression of this patient's chronic renal disease.

ourselves a question. If that small renal biopsy is truly representative of the total mass of the kidney, how many cholesterol emboli should we expect in a total kidney? The patient's renal biopsy was approximately .01% of the total kidney volume, and so if we saw two foci of emboli what would we see in a total kidney? We would have somewhere between 16,000 and 30,000 foci of cholesterol emboli in that kidney (Table 3).

Table 3. Renal Sampling

	Normal Kidney	Patient's Renal Bx	% of Normal Kidney	Approx. # Foci/ Whole Kidney
Volume	130cm^3	0.012 cm^3 (0.016cm^3 before tissue shrikoge)	.0123%	16,250 (32,500/ cortex/kidney)
Number of Glomeruli	620,000 (± 25%)	25	.004%	50,000

Table 3. The small amount of renal tissue obtained for the renal biopsy demonstrated two foci of cholesterol emboli in two arteries/arterioles. If that obtained/observed renal tissue was representative of the kidney(s) as a whole, then how many foci of cholesterol clefts were likely to be present within the entire kidney?

Another way of looking at it is that we all learned and taught that we have about a million glomeruli per kidney; that is not true. Recent studies have shown that we have about 620,000 glomeruli/kidney. We received about 25 glomeruli in our present renal biopsy, so if our biopsy is representative, 25 is about .004% of the total glomeruli in the kidney. Therefore, extrapolating from two foci up, how much would we have in the whole kidney? It would suggest that we would have about 50,000 foci of these cholesterol emboli (from one or multiple embolizations) per kidney (Table 3).

Thus, our diagnosis is cholesterol embolization. I think that is what is causing his recent demise of renal function. The exact way that the embolization leads to the decreased renal function is still not really clear to this day but may be more than just immediate vascular obstruction and downstream ischemia.

Any questions on the renal morphology?

Question - Dr. Patrick McKee: If you knock down less than 10% of the glomeruli would you expect to see this level of impaired function?

Answer - Dr. Fred Silva: Not at all. To knock out that much, to get a serum creatinine of 1.5 or 1.6 on somebody less than a very muscular athlete means that you have really knocked out 60 to 70% or more of the renal function. So to get the creatinine of 3.3 is something like 80%. I really do not know, the mechanism — whether it is more than just vascular obstruction because even if we had 50,000 cholesterol emboli per kidney, you still have 600,000 normal glomeruli and probably 600,000 normal afferent arterioles. The kidney is an end organ structure so if there is occlusion to a larger vessel you are going to involve a lot of down-stream renal parenchyma. However, I think it is probably simplistic and naive to say the renal insufficiency is "just" secondary to the embolization. It kind of reminds me of pulmonary emboli. I know how one or two pulmonary emboli can plug a few vessels and lead to death. I can tell you why cholesterol emboli lower the serum complement or why they lead to eosinophilia, but I cannot answer the question you just asked — which is the key question?

Dr. Patrick McKee: Well, I can come up with good hypothesis for pulmonary emboli, but not for renal cholesterol emboli and renal dysfunction; what is particularly disturbing is that there is no other disease that we saw in the renal biopsy except what was caused by other mechanisms (hypertension).

Dr. Fred Silva: The other points I would add of why I think cholesterol emboli caused the disease, is that we just do not see these emboli in most renal biopsies or in "normal renal tissues." Now you might say you do not see many normal kidneys but there has been a huge Dutch study involving 70 departments of pathology, 8.5 million autopsies, and they found cholesterol emboli in only one third of 1% of autopsies unselected for renal disease.

Question - Dr. LeAnn Olanski: Well, the cardiologists are starting to pay more attention to the inflammatory process going on in the atherosclerotic plaque from which these cholesterol emboli came. Do you think it is possible that this is the pathogenetic mechanism that you have the embolus and the delay is due to the fact you then activate macrophages and have a lot of inflammation that gives you that interstitial fibrosis?

Answer - Dr. Fred Silva: I ran a MedLine search on everything in the English language on "cholesterol emboli" for the last four years. There are about 25 papers per year and they really do not address that question in the last few years. We know that cholesterol emboli activate complement and leads to C5a production, which attracts eosinophils. We know that CD4 positive T cells produce IL5 as do mast cells and eosinophils and IL5 attracts eosinophils. So there has been a suggestion that maybe this is like a form of chronic humoral vascular rejection. But to my knowledge, and

my last literature search, there really was not much more literature on that.

Dr. Chris Kaufman: Well, there is an experimental model and I think there is support for what you say that you can put cholesterol crystals in experimental rat and demonstrate invasion of with macrophages and lymphocytes and the inflammatory reaction and thrombosis and so on.

Dr. Fred Silva: Let me just follow up on that. There are all kinds of experimental studies and some empiric human findings that steroids or prostaglandins might be of help to the patient. It could be that this is like chronic vascular rejection or obliterative transplant arteriopathy.

Dr. David Kem: While the issue of a renal artery stenosis of a single large artery seemingly has been ruled out, there is a possibility, and I think even a probability, that the rapid decrease in renal function might be also due to multiple small renal artery stenoses. Clearly this is still upstream to the glomerulus and you can get a rapid increase in renin. This patient had been administered a non-steroidal agent and while we always look at single artery or large artery, there have been syndromes where you can find multiple small arteries act in a similar way and so even if we talk about only 10% involved, it is possible that the hormonal milieu in terms of prostaglandin-angiotensin interaction in renal blood flow has been so altered that you again get renal shutdown during this period of time.

Dr. Fred Silva: You may be right, obviously I cannot see that under the microscope.

Question: The question I have is if there is any relationship between what one might see in the retina in terms of fat emboli and peripheral cholesterol emboli and also what the relationship is between cholesterol emboli and serum cholesterol. This fellow's cholesterol was fairly low I think.

Answer - Dr. Fred Silva: With regard to the first, the literature would suggest that one of the ways to diagnose this is looking for Hollenhorst plaques which are exactly these cholesterol emboli in the retinal artery. Virtually every organ that has a vascular supply can be involved and has been demonstrated. The kidney, though, is the most common at least in that autopsy study of 8.5 million autopsies that I referred to before. Only 50% of patients with cholesterol emboli have skin findings as Dr. Kaufman said.

Dr. LeRoy Southmayd: Given the association with Coumadin® and the question whether plaque that is being held down by little microclots breaks loose on Coumadin®, forgetting his cardiac disease, should we put this patient on Coumadin® or keep him off Coumadin®?

Dr. Chris Kaufman: I would keep him off Coumadin®. I think there is a very, very high risk of recurrent embolization if he were maintained with a therapeutic Coumadin® level.

SCIENTIFIC

Immunization Rate Comparison for Oklahoma Medicaid Managed Care Population by Age Two: 1995-1998

James S. Millar, MD; Darendia McCauley, PhD; Lynn Mitchell, MD, MPH;
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Processes of care are used as one measure for the quality of care rendered by providers. One example is the immunization of children by the age of two. The Oklahoma Health Care Authority, with the Oklahoma Foundation for Medical Quality, has been tracking childhood immunization rates from 1995 through 1998. The rate calculated included the medical record data and the Oklahoma Statewide Immunization Information System (OSIIS) data set. The standards were based on Advisory Committee on Immunization Practices recommendations and Quality Assurance Reform Initiative standards. The rate of provision of documented immunizations in the Medicaid managed care population under the age of two has improved markedly from 1995 to 1998. The trend analysis suggests there might be areas for continued improvement in the provision of immunization to individuals in Oklahoma's Medicaid managed care population. Further, the OSIIS data is critical for maintaining a uniform data set for immunization informaiion.

Introduction

Quality medical care is a goal of providers, but standards and measures of quality are difficult to define. Processes of care and outcomes may be used as indicators of quality of care rendered by providers. One example of this process of care is the immunization of children by the age of two. The Oklahoma Health Care Authority (OHCA), with the Oklahoma Foundation for Medical Quality (OFMQ), has been studying the documented rate of childhood immunization in the Medicaid managed care population enrolled in the SoonerCare Plus program. SoonerCare Plus is a fully capitated Health Maintenance Organization (HMO) program serving the Aid to Families with Dependant Children (AFDC)/Temporary Assistance to Needy Families (TANF) Medicaid population in and around the three largest metropolitan areas in the state of Oklahoma.

Methods

The immunization rates for each HMO in the SoonerCare Plus program were obtained from 1995 through 1998. Since Medicaid eligibility is a qualifying status for the Vaccines for Children (VFC) program funded through the Centers for Disease Control and Prevention, Medicaid is not a primary payor for immunizations. Medicaid claims data, therefore, cannot serve as a source for documentation of immunization status.

The rate calculation included the medical record data and the Oklahoma Statewide Immunization Information System (OSIIS) data set, a statewide registry of immunizations. This registry, established in May 1995, links 546 sites as of March 1999, including county health departments, private physician offices, hospitals, and schools. The Oracle-based software allows authorized users to interface with the database, find the individual immunization record, and update at the time of any additional immunizations. This provides a central permanent record despite patient changes in location, provider, or health plan.

Medical record abstraction was done on-site in the physician's office by staff of OFMQ to find the immunization data. The standards were based on Advisory Committee on Immunization

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Table 1. Immunization Rates 1995 to 1998

Immunization	1995 N=802 %	1995 N=802 95% CI	1996 N=499 %	1996 N=499 95% CI	1997 N=488 %	1997 N=488 95% CI	1998 N=1140 %	1998 N=1140 95% CI	p-value 1995 versus 1998
Varicella	24.7	21.6–27.7	29.3	25.2–33.4	24.8	20.9–28.7	45.6	42.7–48.5	0.001*
Overall	27.6	24.4–30.7	39.1	34.7–43.5	49.0	44.5–53.5	48.2	45.3–51.2	0.001
Diphtherio-Pertussis-Tetanus	40.9	37.4–44.4	48.1	43.6–52.6	56.8	52.3–61.3	53.7	50.7–56.6	0.001
Hepatitis B	36.9	33.5–40.3	53.5	49.0–58.0	63.5	59.2–67.9	66.1	63.3–68.9	0.001
Polio	55.6	52.1–59.1	62.5	58.2–66.9	69.1	64.9–73.3	67.9	65.1–70.6	0.001
Measles-Mumps-Rubello	61.0	57.5–64.4	66.1	61.9–70.4	71.5	67.4–75.6	75.0	72.4–77.6	0.001
Hemaphilus Influenza B	73.8	70.7–76.9	79.0	75.3–82.6	82.4	78.9–85.9	84.2	82.1–86.4	0.001

Table 1. Percentage of study population immunization, with 95% confidence intervals, by year and by immunization type (*Comparison between 1997 and 1998, as varicella first required in July 1996).

Practices[1-8] (ACIP) guideline recommendations for immunization administration, and the Health Care Financing Administration's (HCFA) Quality Assurance Reform Initiative (QARI) standards for conducting focused studies.

Sampling

For all four annual waves of the study, a random sample of cases was selected for each SoonerCare Plus HMO. To be eligible for the focused study, children were required to be a Medicaid recipient continuously enrolled in a SoonerCare Plus HMO for six months, and either be two years old or turn two years old during the respective reporting period. A new sample was selected annually from each HMO and employed the same basic study methodology. The first wave in 1995 was used as a baseline immunization rate for the SoonerCare Plus HMOs.

Quality Indicators

The criteria for compliance included insuring the child had received the following immunizations by age two: four DTP (diphtheria-tetanus-pertussis), three polio (either inactivated polio virus or oral polio virus), one MMR (measles-mumps-rubella), one Hib (hemophilus influenza type b), three HBV (hepatitis B), and one VZV (varicella zoster virus). The overall rate for this study was calculated for the population receiving all of the above, except the VZV. As the VZV was not recommended by the ACIP until July 1996, the overall immunization rate for 1995 through 1998 did not use VZV as a component. The VZV rates for 1995 and 1996 were included in the first two years' data sets at the request of OHCA, and in 1997 and 1998, following the ACIP recommendation.

Interventions

The intervention for each year of the study was listing all the HMOs by name with their associated completion rate in a publication. After the 1995 baseline report, the reports also included the change from baseline for each HMO, and again included all the HMOs by name with their respective data. Study results were also discussed with the HMOs jointly and individually in OHCA management meetings. Suggestions for improvement in documentation were made during the monthly meetings held with the medical directors of the health plans.

Baseline and Remeasurement Procedures

Medical record abstraction occurred on-site at the physician's office at a time mutually acceptable to the provider and the OFMQ staff. The abstraction was performed to find the immunization completion rates. Abstractors were registered nurses, registered record administrators, licensed practical nurses, or accredited record technicians. All abstractors received an orientation and training on the study, the data collection instrument, and data collection requirements. Once data collection was begun no changes to the collection methodology were made. Internal quality control (IQC) was used to attain an inter-rater reliability coefficient greater than 90% each year. A sub-sample equaling 10% of the total sample was used from medical records copied from the on-site visit. The IQC process was implemented for each reviewer after 25% of the assigned records were abstracted, and for each additional 25%. If the error rate exceeded 10%, additional training was provided. Also, the 25% of assigned medical records involved were re-abstracted using a different reviewer.

Toble 2. Relotive Proportion of Immunizotion Documented in OSIIS Registry Only; 1996, 1997 ond 1998

Immunization	1996 N=499 Total Rate %	1996 N=499 % In OSIIS Only	1997 N=488 Total Rate %	1997 N=488 % In OSIIS Only	1998 N=1140 Totol Rote %	1998 N=1140 % In OSIIS Only
Overall	39.1	34	49	19	48.3	21.1
Diphtheria-Pertussis-Tetanus	48.1	32	56.8	19	53.7	20.4
Hepatitis B	53.5	37	63.5	21	66.1	24.4
Palia	62.5	38	69.1	22	67.9	23.3
Measles-Mumps-Rubella	66.1	37	71.5	21	75.0	28.2
Hemaphilus Influenza B	79.0	39	82.4	23	84.2	23.1

Toble 2. The percent of totol immunizotion rote, by type of immunizotion ond by yeor, found only in the Oklohomo Statewide Immunization Informotion System (OSIIS).

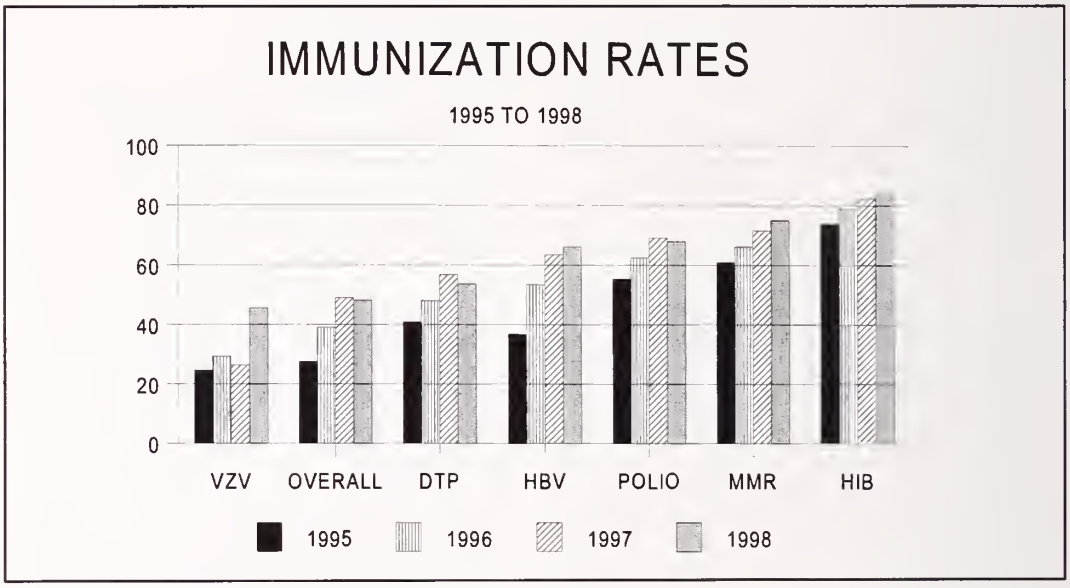


Figure 1. Comporison of totol immunizotion rote, by year and by type of immunizotion, for study populotion.

Population eligibility for the immunization study included Medicaid eligibles who were age two during the study period and who were continuously enrolled in a SoonerCare HMO for a minimum of six months. The number of expected immunizations to be completed was based on the established schedule from ACIP.

Statistical Analysis

Statistical analysis was performed using SAS®, Version 6.12 (SAS Institute, Cary, North Carolina) and Excel® (Microsoft, Redmond, WA). Pearson's chi-square was used to determine difference in rates among study years.

Results

For the four DTP immunizations, (Table 1) a 40.9% completion rate was documented (Fig 1). For 1996, a 48.1% rate of documented immunization—32.9% from the office record and an additional 15.2% from OSIIS. Approximately 32% of the documented immunizations were from OSIIS alone (Table 2). For 1997, there was a 56.8% documented completion rate. Office records documented 45.9% of these; OSIIS records accounted for an additional 11% of the immunizations. Approximately 19% of the documented immunizations were from OSIIS alone. For 1998, 53.7% had evidence for the immunizations. OSIIS alone had 21.1% of the total immunizations recorded. The improvement in the rate of this immunization is statistically significant at a *P*-value less than 0.01 among the years studied.

For the three polio immunizations, the 1995 sample revealed a 55.6% rate. In 1996, the group documented a 62.5% completion rate.

For 1997, a 69.1% rate of documented completion was noted. By 1998 documentation of the three polio immunizations was for 67.8%. The improvement in the rate of this immunization is statistically significant at a *P*-value less than 0.01 among the years studied.

For eligible individuals given at least one MMR immunization by 1995, immunizations recorded gave a 61% rate. For 1996, a documented 66.1% rate was noted. For the 1997 group, a 71.5% rate and in 1998, 75.0%. The improvement in the rate of this immunization is statistically significant at a *P*-value less than 0.01 among the years studied.

For the individuals with at least one Hib immunization, the 1995 group had a 73.8% rate. For 1996, there was a 79% rate, and for 1997, a 82.4% rate was recorded. In 1998, medical records documented a rate of 84.2%. These two years are the only immunization achieving 80% or higher. The improvement in the rate of this immunization is statistically significant at a *P*-value less than 0.01 among the years studied.

For the three HBV immunizations, there was a 36.9% rate in 1995 and in 1996, a 53.5% rate. In 1997, 63.5% had the complete trio. By 1998, a 66.1% rate was documented. The improvement in the rate of this immunization is statistically significant at a *P*-value less than 0.01 among the years studied.

For the VZV, the 1995 group of 802 had 198, for a 24.7% rate. This compares to 1996, with a rate of 29.3%. In 1997, a 26.4% rate was documented. For 1998, the rate of 45.6% was achieved with documentation in medical records and OSIIS. Again, ACIP did not recommend this particular immunization until July 1996. Comparing the two full years after the recommendation (1997 and 1998), the improvement in the rate is significant at a *P*-value less than 0.01 for the two years.

For the overall rates, which includes all the above except for the VZV immunization, the 1995 rate was 27.6%. For 1996, the rate of 39.1% is based on the documentation. The rate of 49.0% for 1997 reflects the documentation of individuals receiving the immunizations. Finally, for 1998, medical records had documentation of all the desired immunization at a rate of 48.3%. The improvement in the overall rate of immunization is statistically significant at a *P*-value less than 0.01 among the years studied.

Discussion

The immunization rate has improved in the four years studied. The rates of the individual immunizations, as well as the overall are short of the 90% goals set by the Centers for Disease Control and Prevention, or the 80% set by OHCA and the SoonerCare Plus plans. The greatest improvement for a single series is for hepatitis B, rising by 29.2% in the four years, from 36.9% to 66.1%. More impressive is the improvement in the overall rate, going from 27.6% to 48.2%, an increase of 75% over the 1995 baseline.

Improvement in the office chart documentation from 1996 to 1998 was noted. The source of the data was not abstracted, and could have been updates in the chart from OSIIS queries. The source of the documentation was not as important as having the documentation. As noted in Table 2, 32% to 39% of the documented immunization were found only in the OSIIS data set in 1996. This had decreased to a range of 20.4% to 28.2% for 1998, still a substantial portion. As the registry was begun in May 1995 on a limited basis, the breakout between office data and OSIIS was not done for 1995. The benefit of the wider availability of this central registry was self-evident, with approximately one in four shots recorded in 1998 only in the OSIIS databank.

The rate of provision of immunizations in the SoonerCare Plus population by the age of two has improved from 1995 to 1998. The trend analysis suggests there are areas for continued improvement in the provision of immunization to individuals in Oklahoma's Medicaid managed care pediatric population. OSIIS continues to work toward becoming a uniform and comprehensive immunization registry for Oklahoma. Native American Medicaid members can receive services through the Indian Health Services (IHS) and tribal providers outside the HMO. Current efforts include working with IHS and tribal provider groups for a more comprehensive registry of immunization information. The rates indicated in this study do not include data from IHS and tribal providers, and are, therefore, an underestimate of immunization status.

It should be noted that the immunization rates produced by the Oklahoma State Department of Health (OSDH) cannot be compared to OHCA rates. OHCA rates reflect a more conservative HCFA rate calculation based on total eligibles rather than actual recipients. This produces a larger denominator, and as a result, the more conservative rate. While the state of Oklahoma needs to aggressively pursue outreach efforts to increase immunization rates, an ordered effort in

documentation, identification, and coordination is also essential to substantiate services across multiple providers and groups.

Required Disclaimer

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Severe Invasive Group A Beta-Hemolytic Streptococcus Infection Complicating Pharyngitis: A Case Report and Discussion

S. Blake Kelly, MD; Lew Dick, MD, MPH

Group A beta-hemolytic streptococcus (GABHS) has long been recognized as a deadly pathogen with manifestations ranging from impetigo to necrotizing fasciitis. Bacteremia from streptococcal pharyngitis is a rare complication. We report a patient presenting with septic shock and diabetic ketoacidosis from streptococcal pharyngitis. The pathophysiology, classification, and treatment of invasive group A streptococcal infection is discussed.

Case Report

A 42-year-old black female was admitted to an Oklahoma community-based, teaching hospital in January 1999. Her husband brought her to the emergency department after finding her obtunded on the bathroom floor. Two days prior to admission, her family physician saw her for a severe sore throat. At that time, she was afebrile with stable vital signs. Her exam revealed an erythematous posterior oropharynx without exudate, and bilateral lymphadenopathy in the anterior neck. A throat culture was taken, and she was prescribed a five-day course of azithromycin for a presumed Streptococcus pharyngitis.

Past medical history included moderate persistent asthma, chronic low back pain, and diet controlled diabetes mellitus. Medications included albuterol, inhaled steroids, and NSAIDs. She was allergic to penicillin, cephalosporins, and sulfa derivatives. There was no history for tobacco, alcohol, or drug use. Physical examination, laboratory findings, and diagnostic evaluation are noted in Tables 1 and 2.

Hospital Course

Diagnosed with septic shock and diabetic ketoacidosis, she was aggressively fluid resusci-

Table 1. Physical Examination

Vital signs:	bload pressure, 125/88; pulse, 111; respiratians, 14; and temperature, 93.6°F by otic thermameter.
General:	unrespansive with a Glasgaw cama scale of three; na signs af iv drug use, saft tissue infectian, ar trauma.
HEENT:	atraumatic; sluggish 6 mm pupils and discanjugate gaze, no gag ar caugh reflex; extremely paar dentitian, na apparent periadantol or peritansillar abscess; mucaus membranes were dry.
Neck:	supple with bilaterol lymphadenopathy but na apparent abscess; na thyramegaly ar bruits.
Heart:	tachycardiac, regular rhythm withaut murmur, gallap, ar rubs.
Lungs:	clear ta auscultatian.
Abdomen:	saft, hypooctive bowel saunds; na hepatasplenamegaly.
Extremities:	pulses were present, capillary refill wos sluggish, skin was caal.

Table 2. Laboratory Findings and Diagnostic Evaluation

White blaad cell caunt, 41.5 x 10.3/mm^3 with o left shift; hemaglabin, 12.0 gm/dl
platelet caunt, 652 x 10.3/mm^3
Electralytes: sadium, 134 meq/L
Patassium: 6 meq/L
Chlaride: 96 meq/L
Blaad urea nitragen: 19 mg/dL
Creatinine: 1.7 mg/dL
Glucase: 937 mg/dL
Acetane titer: 1:64
Albumin: 2.4 gm/dL
Colcium: 7.6 mg/L.
Hepotic enzymes were narmal.
Cerebraspinal fluid and urine analyses were unremorkable.
She was pramptly intubated far airway pratectian with the initial arteriol bload gas demanstrating:

pH, 6.29
Pco_2, 19
Pa_2, 653

Bicarbanate 3 mmol/L, on 100% FIO_2
Past-intubatian chest x-ray as well as all subsequent films revealed na evidence af cardiathoracic disease.
ECG revealed anly sinus tachycardia.

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tated, started on an insulin drip, and admitted to the intensive care unit. Her glucose and electrolytes were managed without difficulty, but she required a dopamine drip to sustain an acceptable blood pressure. Empiric treatment was begun with IV levofloxacin 500mg q24 hours, and IV clindamycin 900mg q8 hours because of her penicillin allergy. Her throat culture done previously in the clinic was positive for GABHS and sensitive to penicillin. Four of four blood culture bottles grew GABHS sensitive to penicillin. Once this information became available, the levofloxacin was discontinued and one dose of IV immunoglobulin, 400mg/kg, was given.

Because isolated strep pharyngitis is a rare source of septic shock, a CT scan of her head, neck, and chest was performed to rule out an abscess. Her profound sepsis qualified her for enrollment in a phase three clinical trial using activated protein-C to treat septic shock. She remained stable and showed marked improvement on day five. She was extubated on day seven, moved out of the intensive care unit on day eight, and discharged home on day ten. Two month follow-up revealed a pleasant female with no obvious deficit or sequelae of this infection.

Introduction

Group A beta-hemolytic streptococcus (GABHS) causes a variety of illnesses which range in severity from impetigo and pharyngitis to necrotizing fasciitis and toxic shock syndrome. Since the late 1980s, there has been a rise in the number of reported cases of invasive GABHS.[1-3] It was also during this time that a toxic shock syndrome (STSS) was described for S pyogenes. Toxic shock syndrome was already a well-known manifestation of invasive staphylococcal infection. The 1993 Working Group on Severe Streptococcal Infections categorized invasive streptococcal infections and defined STSS.[4]

Specific criteria permit a distinction between invasive disease and STSS. Invasive GABHS disease is defined as an infection associated with the isolation of GABHS from a normally sterile body site but not meeting other criteria for STSS or necrotizing fasciitis.[4,5] This includes meningitis, pneumonia, puerperal sepsis, septic arthritis, surgical wound infections, and bacteremia with or without an apparent focus. Hypotension and multi-organ failure are prerequisites for the STSS.[4] Extensive local necrosis of subcutaneous soft tissues and skin as well as isolation of GABHS from a normally sterile body site define necrotizing fasciitis.[4]

Approximately half of patients with necrotizing fasciitis, one fourth of patients with pneumonia, and one sixth of patients with bacteremia due to this organism meet criteria for STSS.[6] Because the number of reported cases of GABHS infections are rising and associated with severe complications, physicians must quickly diagnose and treat patients with this pathogen.

Microbiology

Streptococci are a diverse group of gram positive bacteria that cause a variety of toxigenic and pyogenic infections in humans. As a group, they are catalase-negative, facultatively anaerobic cocci that grow in pairs and chains. In the Lancfield classification system, streptococci are assigned letters A through R based on the their carbohydrate antigens. GABHS have an M antigen and produce various exotoxins correlated with pathogenicity and invasive disease potential.

Incidence and Risk Factors

The Centers for Disease Control and Prevention has estimated the annual incidence of invasive GABHS in this country as 4 to 5 cases per 100,000 persons with approximately 10,000 cases occurring each year.[7,8] Published incidence rates for invasive GABHS range from 1.5 to 7 cases per 100,000 persons annually.[5,6,9]

GABHS is a pure human pathogen. Its incidence is highest among young children and the elderly.[7,10] Known risk factors for invasive GABHS include immunosuppression, HIV, malignancy, diabetes mellitus, and chronic cardiopulmonary disease. Any compromise of the integument such as varicella, burns, or IV drug use places patients at increased risk as well. Varicella has emerged as a particularly important risk factor for otherwise healthy children.[3,11,12]

Pathogenesis

In the last decade, there have been increasing numbers of case reports of necrotizing fasciitis, myositis, and STSS in otherwise healthy individuals with no obvious portal of entry or only minor soft tissue damage such as a bruise or muscle strain at the site of involvement.

Approximately 45-50% of these patients have no obvious portal of entry. This group exemplifies the poorly defined risk factors and pathogenesis of this complex interaction of host defense mechanisms and streptococcus virulence factors. Several studies have shown a relationship between the increased frequency of invasive disease and group A streptococcal

strains of M protein types 1 and 3.[6,13-16] The M proteins are streptococcal surface antigens that prevent phagocytosis of the organism by macrophages and neutrophils.

Streptococcal pyrogenic exotoxins (SPEs) are the substances responsible for the rash of scarlet fever and are powerful cytokine modulators. SPE A and SPE B are powerful toxins and are thought to be important in STSS.[14-17] It is the interaction of a host's immune system with a particular strain of streptococcus M-type, expressing a given SPE that is ultimately responsible for this organism's clinical manifestation.

Disease Management

Patients with severe invasive GABHS need management in an intensive care unit. Patients with septic shock need aggressive fluid resuscitation, cardiovascular monitoring, and inotropic support as necessitated. When soft tissue involvement is apparent, surgical debridement, fasciiotomy, or amputation are essential components of therapy. Antimicrobial therapy should be selected to eradicate the organism. Initial antibiotic selection should cover both staphylococcus and streptococcus species as well as anaerobic organisms if suspected.

Once GABHS is isolated, a narrow spectrum antibiotic may be substituted. Because no resistant strains of GABHS have been isolated, penicillin (2 to 4 million U intravenously every 6 hours) remains the drug of choice.[17] Many experts advocate clindamycin (25 to 40mg/kg per day in three to four divided doses) in addition to penicillin because of its ability to inhibit protein synthesis and decrease toxin production. Penicillin shows diminished activity in the setting of a large inoculum which corresponds to the organism's stationary growth phase. This may explain the dismal success of penicillin therapy with myositis, fasciitis, and deep seated GABHS infections.

It has been demonstrated that a slower replication rate and decreased numbers of penicillin binding proteins (PBPs) are expressed when the organism is present in high concentrations. Since penicillin requires binding to these PBPs in order to break down the cell wall, decreased expression would result in diminished activity of this drug and would result in the high clinical failure rates observed with severe disease. Clindamycin works independent of inoculum size and expression of PBPs, which may explain its theoretical advantage over penicillin against GABHS when a large bacterial inoculum is present. This phenomenon called the Eagle effect has been demonstrated by Eagle et al.[18] In a mouse model of S pyogenes myositis, penicillin was ineffective when treatment was delayed >2 hours after initiation of infection. However, mice receiving clindamycin had survival rates of 100% at 2 hours, and 70% at 16.5 hours.[18,19]

There is anecdotal evidence based on a few case reports that IVIG in addition to standard therapy may be efficacious in the treatment of severe invasive GABHS. Indeed, rapid improvement following single dose therapy has been reported. The mechanism proposed is inhibition of cytokine production by neutralization of circulating exotoxins produced by GABHS.[20,21]

The phase III trial in which this patient participated tests the potential for improving mortality rates in septic patients with intravenous administration of recombinant human activated protein C. In addition to the standard aforementioned therapeutic measures, the patient is randomly assigned to receive either recombinant human activated protein C or saline for a 96 hour period. Activated protein C is a natural anticoagulant generated when thrombin binds to thrombomodulin on the endothelial cell surface in capillaries. As the body's store of activated protein C is depleted, intravascular coagulation intensifies and end organ damage occurs. By replacing activated protein C and restoring balance to the blood clotting cascade, it is hypothesized that morbidity and mortality of patients with fulminant sepsis will be significantly reduced.

The risk of invasive GABHS in close contacts of an index case is uncertain and the role of chemoprophylaxis is controversial. Davies et al estimated the risk to household contacts of index cases to be 2.9 per 1000, almost 200 times the risk for the general population.[6] Certainly contact and universal precautions should be employed when treating a patient with invasive GABHS. For now, physicians are left to their best judgment regarding chemoprophylaxis of household contacts.[22]

Conclusion

This case report along with many others reminds one that GABHS is no longer the dormant pathogen of the early 1900s. Though rare in the general population, its invasive manifestations remain formidable. Physicians confronted with streptococcal pharyngitis should consider patient risk factors and be alert to signs and symptoms of invasive GABHS. Awareness of invasive potential and high clinical suspicion will lead to prompt diagnosis and treatment resulting in improved patient outcomes. ▯

The Authors

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OSMA Delegates and Members Attend AMA Interim Meeting

The Oklahoma Delegation, consisting of 16 delegates and alternates, attended the AMA House of Delegates meeting in San Diego December 5-8. The Oklahoma Delegation submitted five resolutions, including a memorial resolution recognizing the late Perry A. Lambird, MD, for his service to organized medicine and extending sympathy to the Lambirds' surviving children.

A hot topic of discussion at the meeting was the Pain Relief Promotion Act (S. 1272/H.B. 2260), which prevents the use of controlled substances in physician-assisted suicide while allowing physicians to aggressively treat pain. It was supported by a majority vote of delegates on the last day of the meeting. The House of Delegages also voted to work with state and national specialty societies to improve parts of the bill that was introduced in October.

OSMA members attending the meeting included:

AMA Delegates: Jack J. Beller, MD; Norman L. Dunitz, MD; Jay A. Gregory, MD; William H. Hall, MD; David L. Harper, MD; Mary Anne McCaffree, MD; W.F. Phelps, MD; and Gary F. Strebel, MD.

Alternate Delegates: William Bernhardt, MD; Susan Harmon, MD; Carl T. Hook, MD; Mukesh Parekh, MD; Greg Ratliff, MD; Bruce L. Storms, MD; and Boyd O. Whitlock, MD.

Other OSMA representatives: David M. Selby, MD, AMPAC Board; William O. Coleman, MD, OMSS Delegate; D. Robert McCaffree, MD, American College of Chest Physicians Delegate; Clarence Robison, MD; Gary Paddack, MD; Linda Scoggins, OSMA legal counsel; and Brian Foy, Kathy Musson, and Barbara Matthews, OSMA staff.

Medical Student Section: Christine Kendrick, MSIII; Amy Matzell, MSIII; Che Miller, MSIII; and Aaron Sapp, MSIII.

AMA Alliance President-Elect Susan Paddack also attended the meeting along with a number of other OSMA Alliance members.

For additional information concerning this meeting, please refer to the "Last Word" on page 36. A more detailed report of the AMA Interim Meeting, including specific actions taken on OSMA resolutions, will be provided in the January issue of OSMA News.

Brandt to be Honored at "Evening of Excellence"



Edward N. Brandt, Jr., MD, PhD, will be one of the honorees when the OU College of Medicine Alumni Association holds its 16th annual "Evening of Excellence" on January 20 at the National Cowboy Hall of Fame.

Dr. Brandt is chair of the OSMA Council on State Legislation and Regulation and was featured as a "Leader in Medicine" in the August 1998 issue of the *Journal*.

The event is a joint venture of the Oklahoma Health Sciences Center and the state's business and industrial leaders. The purpose is to help Oklahomans become better acquainted with the OU Health Sciences Center and to honor outstanding leaders from the business and medical communities.

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OSMA Seminars Focus on the Evolving Needs of the Health Care Community

The Oklahoma State Medical Association presents the 2000 schedule of educational seminars that will cover the latest guidelines to strengthen members' position within the health care community.

Registration information will be mailed before every seminar. For more details, call Michele D. Smith at the OSMA headquarters at 405/843-9571 or 800/522-9452.

OSMA 2000 Member Services Seminar Schedule

Topic	Month	Location
Beginning Windows 98	January	Oklahoma City/Tulsa
Business on the Internet	February	Oklahoma City/Tulsa
Basic Coding/CPT Coding	March	Oklahoma City
E&M Documentation	March	Oklahoma City
Communicating with Legislators	August	Oklahoma City/Tulsa
Contract Review	September	Oklahoma City/Tulsa
Managing Managed Care Liability	October	Oklahoma City
Legal Introduction -Compliance Program	November	Oklahoma City

Windows 98: In this six-hour class (two consecutive evenings, 6-9 p.m.), you will learn Windows 98 basics, including manipulating windows, exploring the Desktop and Start menus, modifying the environment, multitasking, creating and formatting a WordPad document, and working with Explorer menus.

Intro. to Business on the Internet: In this one-day class you will learn browsing, searching, and retrieving, electronic mail and news groups, and power use. Use bookmarks, hotlinks, and history, configure browser for newsgroups, access FTP files, and configure helper applications.

Basic Coding/CPT Coding: Introduction for those with little or no experience in coding for physician's services. ECM-9-CM Coding, using the index of both coding manuals, using modifiers, and how to assign CPT/ICD-9-CM codes.

E&M Documentation: Evaluation and Management Coding and Documentation presentation explaining requirements for E&M services, breakdown of each of the key components, and learn their elements.

Communicating with your Legislators: Lynne White, OSMA Lobbyist, will present crucial information all physicians should know about the legislative powers, how a bill becomes a law and much more. Learn the elements of bills and resolutions. Every registrant will receive a quick reference workbook detailing the three types of legislative sessions, how to effectively lobby as a citizen, and how and where to write legislators.

Managing Managed Care Liability: All providers are exposed to new types of liability. Understand the risks in order to protect yourself. Focus on: Antitrust Liability, Credentialing Liability, Sources of Utilization Management Standards, Types of Utilization Management, and ERISA Exemption.

Legal Intro. - Compliance Program: The legal aspects of compliance programs; introduction into the needs for compliance programs, the enforcement initiatives, compliance program components, management responsibilities, the policies and procedures, billing and coding compliance, and structural/organizational issues.

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CDC Calls for Prevention Measures for Patients with Diabetes

Each year, between 10,000 and 30,000 people with diabetes die with complications of influenza and pneumonia. "During flu epidemics, people with diabetes are six times more likely to be hospitalized than people without diabetes," said Frank Vinicor, MD, MPH, director of the Division of Diabetes Translation at the Centers for Disease Control and Prevention.

Dr. Vinicor says a pneumococcal shot and an annual flu shot could prevent complications and death associated with pneumonia and the flu, yet, he said, "about half the adults with diabetes do not get a simple, safe flu shot."

CDC has launched a national awareness campaign to encourage people with diabetes to get a flu shot and talk to their doctor about getting a pneumococcal vaccination.

Some ways to incorporate vaccinations as part of a regular diabetes management program include:

* recommending flu and pneumonia shots to patients with diabetes when they come for routine care, especially during flu season (November through March);
* considering instituting standing orders to make the immunizations a routine part of the health care regimen for patients with diabetes;
* educating patients about how to obtain reimbursement for vaccination;
* educating patients about how simple, safe and effective the flu and pneumonia shots are, and
* educating patients with diabetes on the dangers of flu and pneumonia.

Classifieds

Classified ads are 50 cents a word, with a minimum of $25 per ad. A word is one or more characters bounded by spaces. Box numbers will be assigned upon request and will add 6 words to the total. ***Payment must accompany all submissions.*** Orders will NOT be accepted via telephone or fax. Mail ad with payment to OSMA *Journal*, 601 West Interstate 44 Service Road, Oklahoma City, OK 73118. Deadline is the 9th of the month prior to the month of issue (e.g., June 9 for the July issue).

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Articles submitted for publication become the sole property of the *Journal* and must not have been published elsewhere. The Editorial Board reserves the right to edit any material submitted.

Manuscripts must formatted in a standard typeface, and the text must be double-spaced. Authors are required to submit their manuscripts on computer disk, preferably in Microsoft Word or WordPerfect (any PC version) or ascii/ansi/dos text. The disk must be clearly labeled with the manuscript's title, author, and format. A clean printed copy of the document file(s) must accompany all submissions.

Biographical information for each contributing author must accompany the manuscript submission. This information must include: name; gender; mailing address; telephone number; fax number; school of graduation and year; specialty (if any); and current position, title or practice as it relates to the manuscript.

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Style
All manuscripts should approximate the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual of Style*. An abstract of 150 words or less should accompany each manuscript, stating the exact question considered, the key points of methodology and success of execution, the key findings, and the conclusions directly supported by these findings.

Bylines may contain no more than six (6) names and shall include only those individuals who can attest that they have contributed to the conception and design or analysis and interpretation of data, drafting the article or revising it critically for important intellectual content, and the final approval of the version to be published. Other contributors may be recognized in an acknowledgment.

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Accompanying Materials and Illustrations
Materials other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations must be labeled with the author's name, and must be numbered in the order to which they are referred in the article. Tables and figures must also be identified in the order to which they are referred in the article, and must be accompanied by an appropriate title or cutline. The quality of all accompanying materials must be in keeping with the quality of the magazine.

Reprints
Authors will receive reprint order forms from the Transcript Press, PO Box 6440, Norman, OK 73070-6440, with their manuscript proofs. All requests for reprints must be made to the Transcript Press within 30 days of publication.

Obituaries

John Robert DeBiase, MD
1942-1999

John Robert DeBiase, MD, died October 17, 1999. Born February 17, 1942 in Staten Island, New York, Dr. DeBiase attended the Georgetown University School of Medicine and received his medical degree in 1973. Dr. DeBiase was a member of the Oklahoma State Medical Association.

William Clark Cheek, MD
1966-1999

William Clark Cheek, MD, died November 11, 1999. Dr. Cheek was born on April 6, 1966 in Muskogee and attended the University of Oklahoma College of Medicine, where he received his medical degree in 1992. During his career, Dr. Cheek served as Vice President of the Northeastern Radiological Society and the Eastern Oklahoma Medical Society, and was a member of the Oklahoma State Medical Association.

Bill B. Elrod, MD
1923-1999

Bill B. Elrod, MD, died November 17, 1999. Born in Claremore on May 23, 1923, Dr. Elrod served two and a half years in the US Army during World War II, fighting in the Battle of the Bulge. Dr. Elrod received his medical degree from the University of Tennessee Medical School in 1955, and was a life member of the Oklahoma State Medical Association.

Donald E. Johnson, MD
1923-1999

Donald E. Johnson, MD, died November 18, 1999. He was born August 22, 1923 in Carter. Dr. Johnson served four years active duty in the US Army during World War II, and was awarded both the Bronze Star and the Purple Heart. After his military service, Dr. Johnson received his medical degree from the University of Oklahoma School of Medicine in 1954. Dr. Johnson was a lifetime member of both the American Academy of Dermatology and the Oklahoma State Medical Association.

In Memoriam

1999

Thomas Edward Rhea, MD	January 2
H. Ben Yagol, MD	January 19
Paul Elliot Tietze, MD	January 27
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Charles L. Johnson, Jr., MD	February 8
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George R. Randels, MD	October 2
George B. Carter, MD	October 7
John Robert DeBiase, MD	October 17
Theodore Turnbull, MD	October 19
Sol Wilner, MD	October 31
William Clark Cheek, MD	November 11
Bill B. Elrod, MD	November 17
Donald E. Johnson, MD	November 18
Allen E. Greer, MD	November 19

Allen E. Greer, MD
1918-1999

Allen E. Greer, MD, died November 19, 1999. Dr. Greer was born September 14, 1918, in Lincoln, Nebraska. He received his medical degree from the University of Oklahoma School of Medicine in 1942, and was a life member of the Oklahoma State Medical Association.

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Jan. 10	Med. Dept.: "Cause of Death & Determination"	7:00am	1 hour
Jan. 13	Anesth. Dept.: "Compliance in the Practice of Anesthesiology"	6:30am	1 hour
Jan. 14	Cancer Conf.: "Treatment of Early Stage Non-Small Cell Lung Cancer"	7:00am	1 hour
Jan. 18	Family Practice Dept.: "Update on Migraines"	7:00am	1 hour
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Jan. 13	"Risk Assessment & Genetic Testing For Breast Cancer"	12:15pm	1 hour
Jan. 20	"Acute Otitis Media in 2000"	12:15pm	1 hour
Jan. 27	"Clinical Pathology Update"	12:15pm	1 hour
Jan. 18	NeuroScience Institute Lecture Series	7:00am	1 hour
Jan. 19	Ethics For Lunch	12noon	1 hour

Norman Regional Hospital-Joyce Nolen-405-307-1398

Jan. 25	"BioTerrorism"	12:15pm	1 hour

St. Anthony Hospital-Sandy Coury-405-272-6358

Jan. 1	Grand Rounds: Update In Neurology	8:00am	1 hour
Jan. 31	Grand Rounds: Medical Update of Nepro Technology	8:00am	1 hour

St. John Medical Center-Gail Hilst-918-744-2875

Jan. 4	Critical Care Conf.: Cardiomyopathy	12 noon	1 hour
Jan. 6	Critical Care Conf.: Thyroid Disease	12 noon	1 hour
Jan. 11	Critical Care Conf.: Evaluation of Shock	12 noon	1 hour
Jan. 13	Critical Care Conf.: Coagulopathies 2	12 noon	1 hour
Jan. 18	Critical Care Conf.: Medical Ethics	12 noon	1 hour
Jan. 20	Critical Care Conf.: Nosociomial & Vent. Associated Pneumonia	12 noon	1 hour
Jan. 25	Critical Care Conf.: Inerventional Radiology	12 noon	1 hour
Jan. 27	Critical Care Conf.: Case Review	12 noon	1 hour
Jan. 21	Clinical Path. Conf.: Atypical Neuroendocrine Tumors	12 noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator, at 405-843-9571.

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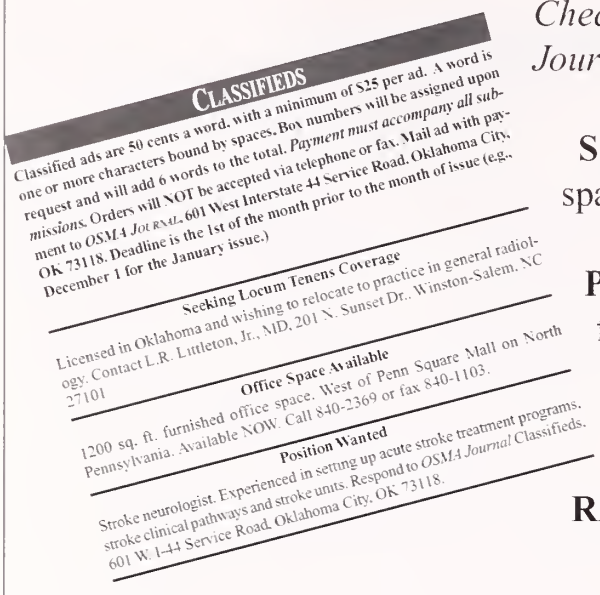
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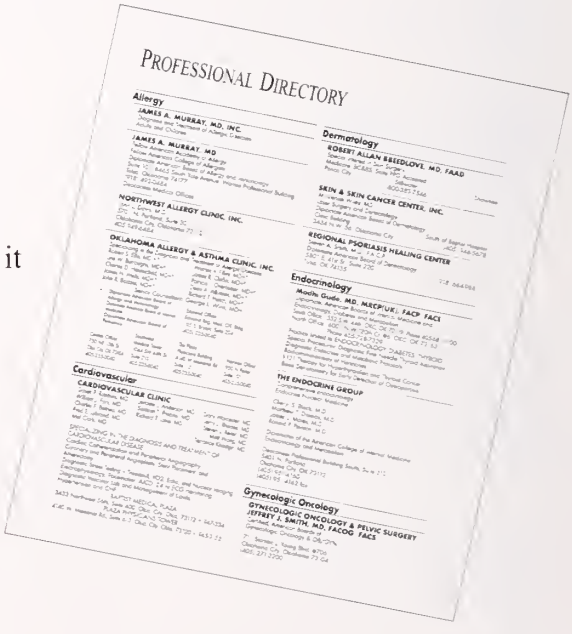
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Physicians' Campaign for a Healthier Oklahoma: OSMA Alliance Perspective

Gordon Deckert, MD, presented a report on the State of the State's Health at the OSMA Alliance's 1999 winter board meeting. The age-adjusted death rate and years of potential life lost in Oklahoma are considerably above the nation as a whole. "We are losing ground compared to the rest of the United States," noted Dr. Deckert.

As Alliance members, we are especially aware of the medical advancements that have occurred in the last half of the 20th century. But as a state, we are falling behind the proverbial "eight ball" from a medical standpoint. It is difficult to believe that in an age of modern medical management, our state continues to experience a decline in overall health status.

For the OSMA, the answer to this challenge comes in the form of the Physicians' Campaign for a Healthier Oklahoma—a special task force created and headed by Robert Weedn, MD, Chair, and Sara DePersio, MD, Vice-Chair. This committee has worked to develop a comprehensive initiative that will improve the health of our citizens by educating the public about Oklahoma's health problems.

The program will be implemented through the OSMA physician leadership. Physicians will be encouraged to become proactive and partner with their patients and colleagues. They will also work in collaborative efforts with the Alliance, community leaders, and other organizations to promote this effort.

A program of this scope cannot be developed overnight. The basic outline is in place, but the infrastructure will continue to be organized over the next few months. The focus will be on prevention, health education, coalition-building, programs, and services. There will also be an additional component to determine the effectiveness of the campaign as it progresses.

The prospect is exciting and the potential to improve the state's overall health status will be the challenge for all Oklahoma physicians. The OSMA Task Force members are scheduling presentations of the program at county medical meetings. They are beginning their effort to educate and inform physicians about the details of the program and enlist their cooperation as active participants.

As OSMA Alliance members we must become educated and informed about this program. The Physicians' Campaign for a Healthier Oklahoma is a program that could impact us all. If you are interested or want more information, contact the Oklahoma State Medical Association at 800/522-9452 or 405/843-9571 or attend the January 10, 2000 board meeting of the OSMA Alliance. Dr. DePersio will present the program to our Board as well as interested Alliance members.

In the words of Thomas Reardon, MD, 1999-2000 AMA President, "I've always felt that if you want to have an impact and make a difference, you have to be involved. That's how you help to shape and direct change. It's not good enough to sit around and complain."



Cheryl Baker
President, OSMA Alliance

"It is difficult to believe that in an age of modern medical management, our state continues to experience a decline in overall health status."

The Last Word

Medicine Day at the Capitol Set for February 16

This year, Medicine Day at the Capitol is February 16 from 9 a.m. to 1 p.m. Tour the capitol, visit with your legislators, then invite them and their staff to a complimentary lunch provided by the OSMA and its Alliance members.

Durant Hospital Honored

Congratulations to the physicians and staff of the Medical Center of Southeastern Oklahoma in Durant for the hospital's inclusion in The Health Network/HCIA 100 Top Hospital list for 1999. MCSO was selected for the honor from among 3,200 hospitals nationwide that receive Medicare payments.

The ranking organization awards benchmark status to hospitals that outdo their peers in areas such as shortening patient stays and adherence to national standards for care. Hospitals were divided into categories by size, with MCSO listed as one of 21 medium-sized hospitals included in the top 100.

The hospital was the only one from Oklahoma included in the rankings.

World Conference on Tobacco OR Health Scheduled

The AMA, American Cancer Society, and Robert Wood Johnson Foundation will host the 11th World Conference on Tobacco OR Health to be held August 6-11, 2000, in Chicago. "With an estimated 1.1 billion smokers in the world, we feel it is critical for leaders in the anti-tobacco community to join together and to develop strategies and initiatives to combat the addiction, morbidity, and mortality resulting from tobacco use," said AMA President-Elect Randolph D. Smoak, Jr., MD.

For more information, visit the World Conference on Tobacco OR Health Web site: http://www.wctoh.org.

It's Okay to Stop Unsafe Drivers

AMA delegates voted to adopt a policy change that approved of doctors alerting state officials when their patients have medical conditions that could make them unsafe drivers. Delegates made the decision at their House of Delegates meeting in San Diego in early December.

"Doctor of the Day" Program Seeks Volunteers

As in past years, this year's "Doctor of the Day" program has designated one month each for certain groups of physicians to participate. The 2000 schedule is as follows:

February:	Tulsa County
March:	Osteopathic Physicians
April:	Oklahoma County
May:	Rural Physicians

For more information, contact Lydia Shirley, assistant to the director of Governmental Affairs at OSMA, 405/843-9571 or 800/522-9452.

Ability to Form Unions Extended to Doctors-in-Training

The National Labor Relations Board recently ruled 3 to 2 that medical residents, interns and fellows may participate in collective bargaining. This action overturned a 23-year-old precedent that considered them students, thus denying the right to form unions and negotiate working conditions as other workers do.

The ruling cited other professions that consider individuals in trainee programs as employees who are protected by federal laws.

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2000 Mark R. Johnson Competition for Excellence in Medical Writing

Students or residents at the University of Oklahoma College of Medicine are eligible for the 2000 Mark R. Johnson award.

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* The student or resident submitting a paper need not be the sole author, but must be the lead author and must have done the majority of the writing.

* The paper must be accepted by the editorial board and be published within the 2000 calendar year.

* The Editorial Board will judge entries for the best scientific paper or opinion piece at their annual meeting in the Spring of 2001.

* The winner (if any) will receive a $500 cash award and will be announced at the Annual Meeting of the OSMA House of Delegates that same year.

* Presentation of the award in any given year will be dependent upon the receipt of eligible papers and at the discretion of the Editorial Board.

* Entries must be clearly labeled as a submission for the Mark R. Johnson Competition and should be mailed to: OSMA *Journal*, 601 W. I-44 Service Road, Oklahoma City, OK 73118.

The memorial trust that funds the competition was established by the friends and family of Mark R. Johnson, MD, who served two decades as editor-in-chief of the OSMA *Journal*.

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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

FEBRUARY 2000 VOL. 93, NO. 2

EDITORIAL
The Pause 43
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE
Get Active in Your Government 44
BOYD O. WHITLOCK, MD, TULSA

SPECIAL
New Investment Policy for the Oklahoma State Medical Association 47
JACK J. BELLER, MD, NORMAN

SCIENTIFIC
Ozone Exposure: A Case Report and Discussion 48
STEVEN PARKS, MD, OKLAHOMA CITY; DAVID W. PAUL, MD, OKLAHOMA CITY

SPECIAL
Improving the Health of Oklahomans Through Clinical Prevention Part 1: Counseling to Decrease Major Risk Factors 52
DAVID J. DEROSE, MD, MPH, SULPHUR; JAMES M. CRUTCHER, MD, MPH, OKLAHOMA CITY; SARA REED DEPERSIO, MD, MPH, OKLAHOMA CITY

LITERATURE AND MEDICINE
A Curriculum for Stimulating the Moral Imagination 63
JERRY B. VANNATTA, MD, OKLAHOMA CITY; RONALD SCHLEIFER, PHD, NORMAN

PRACTICE MANAGEMENT
AMA Litigation Center Pushes for Physician Rights 68
LINDA SCOGGINS, ESQ., OKLAHOMA CITY

CONNECTED CLINICIAN
The Economy of Medical Knowledge 70
CHRIS CANDLER, MD, OKLAHOMA CITY

DOCTOR'S DIARY
The Fabric of Oklahoma Medicine 72
JOE D. HAINES JR., MD, PERKINS

NEWS
Computer Training for Physicians, 74...AMA Sets Leadership Conference, 74...Phillips Named to Cancer Care Post, 74...Video Conference on Asthma Planned, 75...New Standards for Women's Health, 75... Alzheimer's Report Available, 75

DEPARTMENTS
CME, 67...Deaths, 76...In Memoriam, 77....Classifieds, 77...Alliance, 83...The Last Word, 84

ABOUT THE COVER
Medicine Day at the Capitol is March 22, 2000.



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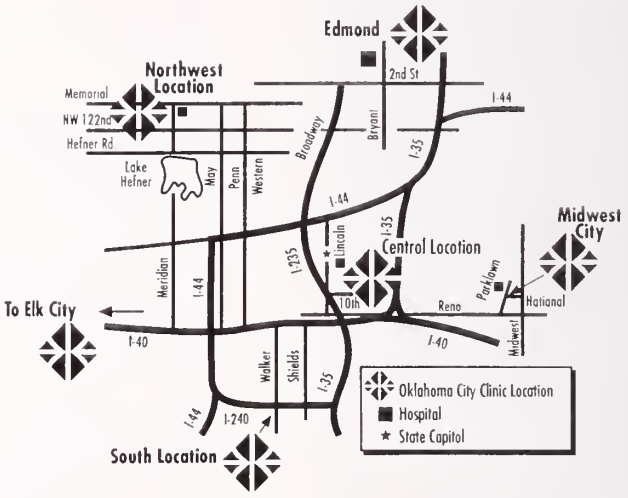
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The Pause...



When was the last time that you paused to consider your profession? For me it is a continual process. I have had this degree posted after my name for over twenty years now, and I continue to pause, to think, to contemplate and to utter a word...of disbelief.

You see, our profession has afforded me tremendous opportunity. Opportunity that I still find difficult to believe.

I am the son of a milkman/salesman/janitor father. We never spoke of life work. We talked about how life would be a struggle and that work would be traded for what was received. He would warn me not to expect much unless I worked hard. I listened and believed.

One of his teaching points was concerning the value of work. He taught me that you give your complete attention to the task, you complete the assignment and, if you have time left over, you find something further to do. Give the man that employed you value for his investment in you.

It was not a lesson about life work, rather it was a lesson about life. A lesson given by a man who worked hard and never really saw the fruit of his work. I don't remember him complaining about his life work...we really never spoke of life work.

With this type of work ethic and work training, one can find opportunity.

So the opportunity of school lessons came easy and being in the right place at the right time opened doors. I ran the same gauntlet that you ran. I had my moments of doubt and frustration. I suffered through the same dehumanization that you noted in your medical pilgrimage.

And yet I pause, for just a moment or two, reminded of the wonders of our profession.

Even on my worst day, I smile about the gift that has been given to me. I am still amazed that no one has figured out that I am not supposed to be here. I still think of medicine as a story that will have an ending and my time of practicing will be over. I fully believe that one day I will wake up and will be back doing the work that I was supposed to be doing all along.

But while I am living my fantasy, I am going to pause and marvel.

March 22, 2000 is Medicine Day at the State Capitol. This serves as a day when our profession is honored for the contribution that medicine makes to this state. The cynics among us will scoff and avoid the celebration or the notoriety. The politicians among our profession will try to give the ten-second sound bite for the evening news. The physician-entrepreneurs will use the moment to make contacts to set up the next deal. Lots of handshakes. Lots of pats on the back. Lots of "good old boy" behavior.

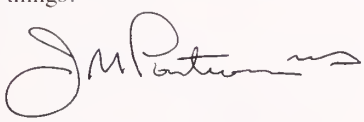
But there will be some physicians amongst our band who will pause and give thought to the pilgrimage that we experience.

They will accept the honor, while considering the pilgrimage that has brought us to this point. There will be the thoughts, the frustrations and the worries about the road that will take us into the future. I will hear my dad's warning that life would be a struggle.

We ought to see Medicine Day as an opportunity to make a statement. We ought to take the time to comment on our health care system. We ought to stand and be counted as being part of the mend, rather than our current status, as part of the problem. We have a choice here; we can see all the short fallings of our health care system and grumble or we can take on that system and mold a better one.

You see the design and improvement of the health care system is currently being abandoned to non-physicians. That allows you and me to grumble and complain and get frustrated that they are never going to get it right. In some ways this is a self-fulfilling prophecy. In some ways we have only ourselves to blame.

On Medicine Day 2000, how about pausing to consider your role in the big scheme of things?



J. Michael Pontious, MD
Editor-in-Chief

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

President's Page

Get Active in Your Government

Your State Medical Association is working hard to be responsive to the needs of its members and their patients.



Your officers and trustees and the OSMA staff are making every effort to be a proactive organization. I discussed last month our activities in the area of public health. We have learned that doctors (not only in Oklahoma but over the nation) want their association to help them primarily in two areas: to be active in state and national legislative areas and to be an advocate in the areas of third party payers.

The state legislative council, under the leadership of Dr. Ed Brandt, had another very successful year. With help from OSMA staff Kathy Musson and Lydia Shirley and our lobbbyists, Lynne White and Dan Draper, many bills were supported and passed that will be beneficial to Oklahoma physicians. The "Peer Review Act" will protect physicians who serve on peer review committees and allow them to continue to do peer review without fear of ending up in court.

The "Do-Not-Resuscitate Act" was positiviely amended to the benefit of physicians and their patients and hospitals. The "SoonerCare Task Force Bill" will extend the SoonerCare Task Force for another year and allow us to continue to meet with the Health Care Authority to correct the inadequacies in this program.

A "Trauma Care Bill" will help establish funding for a trauma system and help reimburse hospitals for uninsured emergency treatment. The above bills were actually initiated by OSMA.

The OSMA strongly supported the "Mental Health Parity Bill" that went into effect Jan. 1, 2000.

We have supported many bills related to the use of tobacco monies. Most of these bills are still alive, and much work is to be done in the coming year. (Watch closely the discussions regarding HB 1002: "The Tobacco Settlement Special Cash Fund Bill.")

As you can see, physicians' practices and their patients have benefited greatly from the efforts of the legislative council and all those who have worked so hard in this area. (Please review the OSMA's "Legislative Report" for 1999 for details regarding the above legislation and much more. These are available from the OSMA office.)

The federal legislative council under the leadership of Dr. Richard Boatsman of Lawton and staff Kathy Musson and Lydia Shirley have been in contact with our legislators in Washington on a regular basis. This council has given input in areas such as the "Bill of Rights" and "Campbell Antitrust Bill" and the "Pain Control Bill." This council has good rapport with our legislators and their staffs and will continue to work with them and the AMA in areas of federal legislation.

Please remember to be involved in the legislative process and let us know your concerns about state and federal legislation. Also, make plans to attend Medicine Day at the Capitol on March 22.

Dr. James Claflin's Council on Medical Services is interested in hearing from all of you regarding your problems related to

insurance, Medicare and Medicaid, and managed care. Staff members Joy Leuthard and Sue Graves are gathering data from the Hassle Factor sheets sent in by all of you and looking for trends or major areas of concern.

Members of this council have worked with representatives from the Health Care Authority to try to correct inadequacies in the state's Medicaid program. The council has worked through the advisory committee to Sooner Care and through regular meetings with our attorney and the Health Care Authority to try to improve patients' access to and the patient care provided through this and related programs. They have met with the Oklahoma State and Education Employees Group Insurance Board to encourage them to give physicians more input into their decision.

The council has worked with the Legislative Council to pass state legislation requiring the insurance companies to give prior notice to physicians regarding any reimbursement changes. The Subcommittee on Managed Care recently had a successful meeting with several managed care (HMO) medical directors. They discussed some of the trends noted through the Hassle Factor Log—such as delayed payments, multiple drug formularies, and staff and physician's time required in obtaining pre-certification. This was believed (by both sides) to be a productive meeting and another will be scheduled soon after the first of the year.

Through the efforts in these areas, I think physicians' lives will be a little easier and freer of hassles and the care of their patients will be a little better.

I hope the above will help all of you to have a better understanding of what your state association is doing.

I hope that this information will help all of us realize that because of OSMA, the problems and hassles related to the practice of medicine are lessened and the care of our patients is improved.

If there are any questions about, or suggestions regarding any of the above, please do not hesitate to call, FAX, or e-mail me.

Sincerely,



Boyd O. Whitlock, MD
OSMA President

Phone 918/494-0594
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E-mail MWhitlock@worldnet.att.net

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New Investment Policy for the Oklahoma State Medical Association

At the November 1999 Board of Trustees Meeting of the Oklahoma State Medical Association, the Board adopted a new policy for managing the Association's funds.

Since 1993, OSMA had maintained a policy of dividing its money into two separate funds. One of these funds was the Reserves (Long-Term Investments), an account invested in a highly-restricted investment vehicle that was returning a net of 5.75% - 6.00% annually. This fund totaled approximately $1.4 million at the time of the change in policy.

The second fund was Cash and Cash Equivalents (operating). Over the 22 months prior to the change in policy, the balance of the operating account had never been less than $1 million and was generating a return of 2.75% - 3.00% on an annual basis.

After a detailed investigation of different options for investing these funds, the Committee on Finance, Personnel and Compensation made a recommendation to the Board of Trustees to invest these funds in a more prudent and fiscally responsible manner.

The Reserve (Long Term) Funds are now invested in nine different investment vehicles that, over the last 10 years, have had an average cumulative, weighted return in excess of 13% annually. OSMA now has $1.4 million invested in this manner, and the organization has also set aside $250,000 in a series of rolling certificates of deposit generating an average return of 6% that can be used for emergency expenditures.

The third category of funds in the Operating Account, the equivalent of a day-to-day checking account for operating the business. The daily balance of this fund will be generating 5% - 5.5% on an annualized basis.

This new fiscally responsible, prudent investment policy for OSMA will assure an improved source of non-dues revenue for the operation and reserve support for OSMA compared to the previous investment policy. Using the last ten years' historical averages, it is projected that our investment income will increase from approximately $160,000 annually to approximately $280,000 annually with a decrease in fees paid to the manager of our investments from approximately $3,000 annually to zero.

I would be more than happy to review any of this information in much more detail with any member of OSMA. Please contact me through the Oklahoma State Medical Association at 405/843-9571 or 800/522-9452.



Jack J. Beller, MD
Secretary-Treasurer
1999-2000 OSMA

Ozone Exposure: A Case Report and Discussion

Steven Parks, MD; David W. Paul, MD

A 45-year-ald man working with azone presents with evidence af sinusitis, mucus membrane irritatian, sleep disturbance and shartness af breath. Naturally accurring ar manmade, azane may damage pulmanary alvealar type I cells at significant expasure levels. EPA and OSHA regulate expasure cancentratians. Studies show dose respanses with exposures. Supporting epidemiolagical studies are reviewed briefly. Limiting patential far excess expasure is key ta preventian. Recagnitian af azane as a patential expasure in the Oklahama warkplace is key ta symptam management.

Case Report

A 45-year-old man presented to clinic in August 1997 reporting episodes of eye irritation and headaches first noticed in October 1995. The headaches were episodic, occurring two to three times a week, for six to eight hours at a time. Shortness of breath, which has remained stable over time occurring two to three times a week for four to six hours at a time, started in April 1996. Eye irritation bothered him more than shortness of breath.

His symptoms seemed aggravated performing his usual work activities. He felt better away from work, and worse after returning to work for a few shifts. In February 1997, he had onset of restless sleep; tossing, turning, and waking up tired. In July, 1997, workplace air conditioning went out. He reported a dramatic increase in symptoms at that time. He reported no previous work-related injuries or illnesses, surgeries, hospitalizations, allergies to medications, pollen, mold, or chemicals, or previous problems with asthma or sinusitis.

He began cleaning smoke-damaged clothing in April 1995. Ozone is used to remove odor and disinfect the clothing. He noticed an "electrical" smell in this workplace. Previous work was in home repair, maintenance, plumbing, and heating and air conditioning without similar problems. He had a 10 pack/year smoking history. Family history was negative.

Nares showed moderately edematous turbinates bilaterally. Otherwise, examination was normal. Chest x-ray showed no active disease. Sinus x-rays were consistent with a minimal right frontal, ethmoid, and maxillary sinusitis. CBC showed a minimal elevation of white cell count to 11.5. Pulmonary function tests revealed FVC 6.08 (121% predicted), FEV1 4.30 (107% predicted), and FEV1 FVC 71%.

Ozone

Ozone is a powerful oxidizing gas formed in earth's lower atmosphere when products of combustion (volatile organic compounds and nitrogen oxides) react with oxygen in the presence of sunlight (UV radiation). Ozone can be produced around artificial UV radiation, gas-shielded welding, or high-voltage electricity. Composed of three oxygen atoms, ozone is a naturally-occurring bluish gas, primarily found in the upper atmosphere. This normal ozone layer protects earth by absorbing UV radiation and is not a respiratory hazard to surface dwellers. Ozone in this layer may enter aircraft cruising at high altitudes, posing an occupational hazard to pilots and flight attendants.[1]

Pathophysiology

When inhaled, ozone reacts with lung tissue forming oxygenated radicals. Animal studies

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show reactive free radical intermediates interact with alveolar type I cells, possibly at the cell membrane, causing necrosis. Ozone inhibits pulmonary macrophages[2] in animals, increasing susceptibility to bacterial infection. It is postulated ozone functions similarly in humans, causing direct tissue damage and immune dysfunction.

The physical and chemical characteristics of ozone have some effect on ozone deposition in the lung. Poorly water-soluble, 50 to 60 percent of inspired ozone will deposit between the nasopharynx and alveoli, mostly from the terminal bronchioles to the alveolar ducts, influencing types of symptoms and pulmonary function changes which may occur.

During exercise, one's tidal volume and respiratory rate increase allowing greater ozone exposure to deep lung tissue and greater exposure per unit of time compared to sedentary activity. In the workplace, sedentary workers likely tolerate higher concentrations of ozone due to smaller tidal volumes and lower respiratory rate.

Regulatory

Recognizing ozone's potential health effects, the Environmental Protection Agency set the national ambient air quality standard (NAAQS) for ozone at 0.12 ppm. Levels above this standard can subject a city or state to fines or other regulatory response. For the workplace, the American Conference of Governmental Industrial Hygienists recommends a short-term exposure standard of 0.12 ppm for a one-hour average and a ceiling limit of 0.1 ppm. The Occupational Safety and Health Administration's legally enforceable permissible exposure limit is 0.1 ppm averaged over an eight-hour shift.[3]

Dose Response

Most individuals begin to smell the pungent "electrical" odor of ozone at levels around 0.02 ppm. At concentrations slightly higher, 0.4 to 0.5 ppm inhaled for three hours a day may cause a reduction in forced vital capacity and airway conductance. At 2 ppm or above, respiratory symptoms may include substernal chest pain, shortness of breath, and irritation of mucus membranes. Membrane irritation results in cough and eye irritation. Heavier exposures may result in radiologic signs similar to pulmonary edema. At concentrations of 5 ppm or greater, exposure can be fatal after exposures as short as one hour.[4]

Exposure Sources

Humans are potentially exposed in many settings. Ambient environmental ozone is a problem in highly polluted urban areas. Exposures may occur in industries utilizing ozone to sterilize water, bleach flour, or deodorize (mask) organic effluents. Air conditioning units and copy machines produce trace amounts. In well-ventilated areas, ozone from these machines should not be a problem. However, large air conditioning units not properly installed, in poorly ventilated areas, or poorly maintained have the potential to produce significant levels. Gas-shielded welding can produce significant levels.[4] The print and silk-screening industries use UV light or ozone to cure special inks and may also produce significant concentrations.

Epidemiology

One hundred two nursing students from Los Angeles and Santa Barbara[5] were followed for 931 days using self-reported pulmonary symptoms. An average of 61 students reported each day. Symptoms included cough, eye irritation, headache, phlegm production, and shortness of breath. For this study, exposure was defined as the ambient environmental ozone level recorded each day in those cities. Exposure effect was the self-reported symptom each student experienced. An exposure effect relationship was then statistically correlated. Confounding factors such as temperature, carbon monoxide, and nitrogen dioxide were taken into account. Results showed high oxidant days (>400 ppb, or 0.4 ppm) were slightly correlated with headache. Significant correlation to eye discomfort and cough was established. There was a clear-cut threshold for prevalence of cough at 0.2 ppm.

In another study, cyclists were studied using ozone levels, symptoms, and pulmonary function tests, comparing pre-exercise parameters with post-exercise parameters.[6] Twenty-three cyclists were studied during the summer months when ambient ozone levels were highest. An exposure effect was defined as a change between pre- and post-exercise parameters, including symptoms (shortness of breath, chest tightness, wheeze, cough, and eye irritation) and pulmonary function test results. There was a correlation between changes in ozone levels and complaints of shortness of breath, chest tightness, and wheeze. Lung function changes in forced expiratory volume in one second (FEV1) and functional vital capacity (FVC) correlated with ozone levels of 100 micrograms per cubic meter or above.

One chronic exposure study involved a community in California considered a high pollution area. The study was reported as a case control study in 1977, but with follow-up in 1987. Initially symptoms of chronic obstructive pulmonary disease correlated strongly with total suspended particles in the air.[7] However, the 1987 follow-up revealed an association between ozone levels and symptoms of asthma (relative risk 1.40 if exposed to 200 mcg/m^3 or greater for more than 500 hours a year). Men in the study showed an increased risk for asthma with ozone exposure (RR 3.12, 95% CI 1.61–5.85).

At Johns Hopkins, eight normal adults were included in an ozone study and acted as their own controls. They were first administered filtered air. Pulmonary function was measured before and after, including peripheral lung resistance. They underwent bronchoalveolar lavage to look at types of cells present in the airways. At a later date, the same subjects were administered 0.35 ppm ozone, and tests repeated. Comparisons were made between air and ozone test results. Correlations were examined between numbers of inflammatory cells and pulmonary function parameters. The inflammatory cell count increased in the ozone postexposure tests. There was a correlation between ozone exposure and decreased FEF 25–75 percent as well as increased fibrinogen levels.

Summary

Acute exposures, chronic exposures, and laboratory exposures to ozone are all important elements in the study of ozone's effects on a human respiratory system. Acute exposure studies generally reveal increasing exposure results in increasing symptoms. In general, pulmonary function tests in these studies are equivocal.

Chronic exposure studies are difficult to interpret. These studies rely on ambient environmental ozone levels; however, ambient air is a mixed bag of pollutants. These pollutants are difficult to control for, therefore difficult to isolate the effects of ozone from effects of other pollutants. Another difficulty is lack of historical records of ozone levels. These levels have been recorded consistently in only a few urban areas. Further, one can only estimate ozone exposure levels on an individual basis.

Apart from studies correlating ozone exposure with health effects retrospectively, further understanding of ozone's pulmonary effects can be inferred from laboratory studies. These are usually experimental studies using human volunteers exposed to known concentrations of ozone. Controlled human studies with ozone are the best way to assess acute damage to the respiratory tract. Generally, these experimental studies show inflammatory reaction with changes in small airway function.

Conclusion

Ozone is a problem arising mostly in urban areas. With increased use of automobiles, ozone is no longer exclusive to cities, and increasingly is a suburban and rural problem as well. Workers in the welding, printing, and airline industries more likely to encounter significant occupational ozone exposure. Closed buildings, inadequately ventilated copy machines, electrostatic air purifiers, or poorly maintained air-conditioning units provide significant potential for exposure.

Potentially a significant workplace hazard, ozone can produce acute effects on the respiratory tract by initiating or exacerbating respiratory diseases such as asthma, sinusitis, and chronic bronchitis. At high exposure levels pulmonary edema or death may result.

Hopefully, with further experimental studies, the exact mechanisms of airway damage from ozone can be elucidated. So far, we know ozone initiates an irritant effect on respiratory epithelium of the smaller airways with resultant activation of inflammatory mediators capable of producing changes in lung function.

Prevention

At a population level, reducing use of fossil fuels should lessen environmental ozone levels on the planet's surface. Carpooling or using public transportation are known to be effective in reducing ambient environmental levels.

The primary method to prevent accumulation in the workplace is good ventilation. Maintaining electrical equipment (air-conditioning units, copy machines) will limit accumulation. Adequately ventilating buildings and around welding, printing, or copy machines should avoid significant exposure to ozone.

If prevention fails, symptomatic care can be given using analgesics for headache and cough medicine as appropriate. Most cases resolve quickly, with only a few lasting up to one or two weeks.[9] J

The Authors
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SPECIAL

Improving the Health of Oklahomans Through Clinical Prevention Part 1: Counseling to Decrease Major Risk Factors

David J. DeRose, MD, MPH; James M. Crutcher, MD, MPH; Sara Reed DePersio, MD, MPH

Compared to other states, Oklahomans suffer higher levels of morbidity and mortality from several common conditions—coronary heart disease, chronic lung disease, stroke and injury. Unhealthy personal behaviors contribute significantly to each of these conditions, thus rendering them at least partially preventable by changing those behaviors. Research has shown that many patients will modify unhealthy behaviors as a result of services provided by physicians or staff in their offices, often with briefly delivered messages.

In this report we will discuss the most common preventable illnesses suffered by Oklahomans and the risk factors associated with those illnesses. Physicians should make maximum use of their ability to promote healthy behaviors by their patients, with emphasis on the risk factors associated with significant morbidity in the state. They should also focus on those risk factors patients are likely to change following physician counseling, as determined by prevention research and described in the U.S. Preventive Services Task Force document *Guide to Clinical Preventive Services*.

In general, physicians should consistently deliver messages that address tobacco products, alcohol and other drugs, the use of seat belts, and diet and exercise. Also, they should recommend that all women of childbearing age who are capable of becoming pregnant take a multivitamin containing folic acid daily.

Oklahomans are not particularly healthy people. That is the conclusion of "The State of the State's Health," an annual report first published in 1997 by the Oklahoma State Department of Health and the Oklahoma Board of Health.[1] That report, which was the first to analyze the overall health of the citizens our state, found that for many of the commonly used health indicators (overall death rates, and deaths from coronary heart disease, stroke, chronic lung disease, and injuries) we rank significantly worse than most other states. Our poor health has also been noted at the national level. The ReliaStar Financial Corporation, which annually ranks the health status of all states, recently reported that Oklahoma dropped from 27th in 1990 to 44th in 1997.[2] We thus hold the unenviable distinction of being the only state to experience a decline in health status since 1990. These findings have shocked many people and should serve as a rallying call for all Oklahoma health professionals—why do our citizens suffer a greater burden of poor health than other states, and what can we do to change that?

Although the question of how best to improve the health of our population is undoubtedly complex, one thing seems clear—prevention must play a central role in these efforts. When we examine the leading causes of death and disability in the U.S. and in Oklahoma, a significant proportion of each of these conditions is potentially preventable.[3] Indeed, for the conditions that cause the greatest amount of illness in our population, changing high-risk behavior is currently the only viable option for decreasing the disease burden.

Prevention is multidimensional and different preventive efforts may be employed at various levels in society. Some issues are best addressed by means of social policies, such as laws that require the use of seat belts, or that ban smok-

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ing in public places. Other health issues require public health and medical professionals who work full-time on prevention efforts, such as controlling outbreaks of infectious disease and maintaining the safety of the food and water supply. Practicing physicians, however, also play a vital role in prevention efforts through interventions they provide in their office, such as counseling to change unhealthy behaviors, screening to identify and treat disease in early stages, and immunization against numerous infectious agents.

Prevention activities are certainly not new to physicians for they have been practicing them for years. However, numerous obstacles have prevented their maximal utilization, such as uncertainty about the efficacy of many of the activities, inadequate time to deliver a large number of recommended preventive services, and lack of compensation for those services. Some of these obstacles have been alleviated to some degree by research and recent initiatives. Other obstacles remain and must be addressed. Our challenge now is to address our major health problems with clinical preventive services of *proven efficacy*.

In this article and two others to follow, we will explore the role of clinical prevention in addressing the excess disease suffered by Oklahomans. This first article will address counseling; the second, screening; and the third will discuss immunizations and chemoprophylaxis. We cannot cover all issues, and many important preventive interventions will not be discussed. Our intent is to focus on the interventions associated with the greatest degree of illness in Oklahomans, those proven to be effective, and those that we hope virtually all health care professionals will utilize. A thorough review of clinical preventive services can be found in the references described below.

Clinical Prevention: Past and Present

The idea of providing preventive services to asymptomatic persons has evolved considerably since 1922 when the American Medical Association (AMA) first recommended that all persons receive an annual physical examination. That recommendation was in effect until 1983, when the AMA withdrew support of a standard annual exam in favor of individualized periodic health visits. The modern age of clinical prevention began the following year, in 1984, when the U.S. Public Health Service (USPHS) assembled a panel of preventive medicine experts to address the rapidly growing body of knowledge concerning clinical preventive services. That panel, the U.S. Preventive Services Task Force (USPSTF), was asked to review and synthesize current preventive medicine research and make recommendations to physicians. The USPSTF, which collaborated closely with all major primary care specialty societies, completed its task with the 1989 publication of *The Guide to Clinical Preventive Services*. A reconvened task force published a second edition of the Guide in 1996.[4]

The *Guide* presents a thorough analysis of the science of clinical prevention in an attempt to document which approaches have been clearly shown to decrease morbidity and mortality in asymptomatic Americans. The *Guide's* focus is on clinical preventive activities—tasks that could be accomplished in a physician's office—as opposed to community-based preventive services. Importantly, the *Guide* was not meant to merely be a long list of preventive activities that physicians "should be doing." Instead, the task force took a very conservative approach and only recommended interventions of documented effectiveness. This strict, evidence-based approach has helped to alleviate some of the "uncertainty factor" which has been labeled as a reason why physicians often underutilize preventive services.

The effort to improve the utilization of preventive services was further enhanced by a 1994 USPHS initiative called "Put Prevention into Practice." That program, with its companion book *The Clinician's Handbook of Preventive Services*,[5] is a collection of resources that physicians can use to help them integrate preventive services into their practices.

In Oklahoma, the State Medical Association has recently launched its own prevention initiative. The "Physicians' Campaign for a Healthier Oklahoma" seeks to utilize a variety of prevention-oriented efforts, including the promotion of clinical prevention, to address the health problems described in "The State of the State's Health."

Although the USPSTF reviewed over 100 interventions addressing 60 different illnesses and conditions, all clinical prevention efforts can be categorized into three general types of services: 1) Counseling; 2) Screening, and; 3) Immunizations and Chemoprophylaxis. Within each of these categories, recommendations are broken down by age group. Table 1 lists the recommended counseling interventions; future articles will present the recommendations for screening and immunizations. The *Guide* and the *Clinician's Handbook* both emphasize that

Table 1. Age Specific Clinical Counseling Recommendations

Birth to 10 years

Injury Prevention
- Child safety car seats < 5 yr
- Lap-shoulder belts > 5 yr
- Bicycle helmet, avoid bicycling near traffic
- Smoke detector
- Flame retardant sleepwear
- Water heater < 120-130 deg F.
- Window/stair guards, pool fence
- Safe storage of drugs, toxic substances, firearms and matches
- Syrup of ipecac
- Poison control phone number
- CPR for parents/caregivers

Diet and Exercise
- Breast feeding; iron-enriched formula and foods
- Limit fat and cholesterol intake; maintain caloric balance
- Emphasize grains, fruits and vegetables
- Regular physical activity

Substance abuse
- Effects of passive smoking
- Anti-tobacco message

Dental Health
- Advice about baby bottle tooth decay
- Regular visits to dental care provider
- Floss, brush with fluoride toothpaste daily

Ages 11 to 24 years

Injury Prevention
- Lap-shoulder belts
- Bicycle/motorcycle helmets
- Smoke detector
- Safe storage/removal of firearms

Substance abuse
- Tobacco cessation
- Avoid underage drinking and illicit drug use
- Avoid alcohol/drug use while driving, swimming, boating, etc.

Sexual behavior
- STD prevention: abstinence, avoid high-risk behavior, condoms/female barrier with spermicide
- Unintended pregnancy: contraception

Diet and Exercise
- Limit fat and cholesterol intake; emphasize grains, fruits, and vegetables
- Adequate calcium intake (females)
- Regular physical activity

Dental Health
- Regular visits to dental care provider
- Floss, brush with fluoride toothpaste daily

Ages 25 to 64 years

Substance abuse
- Tobacco cessation
- Avoid alcohol/drug use while driving, swimming, boating, etc.

Diet and Exercise
- Limit fat and cholesterol intake; emphasize grains, fruits, and vegetables
- Adequate calcium intake (females)
- Regular physical activity

Injury Prevention
- Lap-shoulder belts
- Bicycle/motorcycle helmets
- Smoke detector
- Safe storage/removal of firearms

Sexual behavior
- STD prevention: abstinence, avoid high-risk behavior, condoms/female barrier with spermicide
- Unintended pregnancy: contraception

Dental Health
- Regular visits to dental care provider
- Floss, brush with fluoride toothpaste daily

Ages 65 and older

Substance abuse
- Tobacco cessation
- Avoid alcohol/drug use while driving, swimming, boating, etc.

Diet and Exercise
- Limit fat and cholesterol intake; emphasize grains, fruits, and vegetables
- Adequate calcium intake (females)
- Regular physical activity

Injury Prevention
- Lap-shoulder belts
- Bicycle/motorcycle helmets
- Smoke detector
- Safe storage/removal of firearms
- Water heater set to < 120-130 deg F
- CPR training for household members

Dental Health
- Regular visits to dental care provider
- Floss, brush with fluoride toothpaste daily

Sexual behavior
- STD prevention: safe sex practices

no single set of preventive services is appropriate for all patients in all settings. Clinicians should be selective in ordering tests and providing preventive services based upon the needs of the population they serve.

Focused Counseling to Address Major Risk Factors

For Oklahoma, the recent developments in clinical prevention seem particularly timely. Now more than ever physicians need to understand and employ preventive services to address our state's most important health problems. The five leading causes of death in Oklahoma are heart disease (34%), cancer (22%), injuries (7%), stroke (7%), and chronic obstructive pulmonary disease (COPD) (5%). Compared to other states, our death rates are significantly higher for all of these conditions except cancer. Most alarmingly, our death rate for injuries exceeds the U.S. average by 24%; while our death rates are 18% higher for COPD, 17% for heart disease, and 13% for stroke (1996 and 1997 data). For cancer, the U.S. as a whole has experienced little change in death rates over the last 15 years, while Oklahoma has seen a small rise in malignancy death rates over that same time period.

There is clearly a strong association between our leading causes of death and several personal behaviors—smoking, diet, physical activity, alcohol and drug abuse, and inadequate attention to safety precautions (especially as pertains to motor vehicles). Can physicians impact these behaviors by counseling their patients? A common response is that there is no time for long, behavior modification sessions in today's time-pressured medical practices. However, research has shown that some of the most cost-effective prevention counseling can be delivered in less than a minute. And although counseling is not

perceived by all physicians as their role ("our job is diagnosing and treating disease"), we are in a unique position to affect personal behaviors that contribute to our leading causes of illness. The potential impact of that effort for our patient's health was expressed by the USPSTF conclusion: "...clinician counseling that leads to improved personal health practices may be more valuable to patients than conventional clinical activities such as diagnostic testing."

Clearly, changing unhealthy personal behaviors is critical in addressing our state's health problems, and the physician's role is vital in that effort. In the remainder of the paper, we will discuss the most common risk factors that contribute to excess morbidity and mortality in Oklahoma residents, and explore the physician's role in changing those behaviors.

The Message to Stop Smoking

Smoking is the leading cause of preventable death in the nation and Oklahoma. Over 400,000 Americans die each year from tobacco-related causes, including 6,000 Oklahomans. And, as usual, Oklahoma fares worse than average in this category; we rank among the top 10 states in smoking attributable death rates and in smoking related costs.[6]

Tobacco is a lethal accomplice for many of our leading causes of death. As many as 30% of all heart disease deaths in the U.S. are tobacco related, and only two states have worse coronary heart disease death rates than Oklahoma.[7] Almost 30% of cancers in the US are tobacco related, including 87% of lung cancers.[8] Also, it is estimated that over 80% of COPD deaths in the US are due to smoking,[9] and only four states have higher deaths rates for total lung diseases than Oklahoma.[10] The economic cost is also high—annual direct medical costs related to smoking in Oklahoma are about $390 million.

Clearly, smoking is a behavior that should be attacked from all angles by all health care professionals. Research has shown that physicians can make a sizable impact in this area. The USPSTF concluded that: "Even very simple interventions by clinicians can lead to long-term quit rates of 5-10%." Although this may seem less than impressive, even a 5% quit rate would save hundreds of lives and millions of dollars in our state. Seen from another perspective, such interventions could double smoking cessation rates in Oklahoma.

What are these simple interventions? They involve nothing more than asking patients about smoking status, suggesting that they quit, and providing brief reasons why stopping would benefit their health. Although physicians may assume that everyone understands the risks of smoking, data indicates the contrary. Results of a recent national survey revealed that only 40% of current smokers believe they have a higher than average risk of cancer, and only 29% think they have a higher risk of heart attack.[11]

To increase the likelihood of success, the physician must deliver a clear and strong message,[5] such as:

"I think it is important for you to quit smoking now and I will help you. Cutting down when you are ill is not enough."

"As your clinician I need you to know that quitting smoking is the most important thing you can do to protect your current and future health."

Effective messages can also personalize risks by linking smoking with a current health concern. For example, an elevated cholesterol reading can provide the opportunity to discuss the additional heart disease risk exacted by smoking. Emphasizing the harmful effects of secondhand smoke on children may provide powerful motivation for parents and grandparents.

There are four key components to a successful office-based smoking cessation program:

1. Systematically identify smokers. Office staff can help with this. Consider using stickers on charts to identify smokers.
2. Strongly advise all smokers to stop smoking.
3. Ask every smoker if they are ready to make a quit attempt.
4. Assist patients who are ready to quit. Assistance may come in the form of prescriptions for pharmocologic agents, self help materials, or referral.

How are Oklahoma physicians doing when it comes to counseling their patients about smoking? Table 2 summarizes physician counseling practices for a variety of risk factors. To physicians' credit, smoking is frequently discussed with patients (see question 6). However, we still have room for improvement; although about 75% of respondents said they had ever been advised to quit smoking by a physician, only about half had heard that message in the last year. The "stop smoking" message should be delivered at every opportunity.

Addressing Problem Drinking

Excessive use of alcohol is a widespread problem in the U.S. More than 100,000 deaths are attributed to alcohol each year and over half a

Table 2. How Oklahoma Physicians Are Doing When It Comes To Basic Prevention Messages. Source: 1997 Oklahoma Behavioral Risk Factor Surveillance System survey. (Number equals percentage of respondents; N=1881)

	Yes, within the past 12 months	Yes, within the past 3 years	Yes, 3 or more years ago	No
1. Has a doctor or other health professional ever talked with you about your diet or eating habits?				
Male	27.5	9.1	4.1	59.1
Female	33.0	7.1	5.4	54.2
2. Has a doctor or other health professional ever talked with you about your physical activity or exercise?				
Male	30.6	7.8	3.6	57.7
Female	35.5	7.0	4.0	53.2
3. Has a doctor or other health professional ever talked with you about your injury prevention, such as safety belt use, helmet, or smoke detectors?				
Male	6.7	1.4	0.8	90.8
Female	7.4	1.6	0.6	89.7
4. Has a doctor or other health professional ever talked with you about drug abuse?				
Male	5.0	1.2	1.7	91.8
Female	4.4	1.3	0.7	93.2
5. Has a doctor or other health professional ever talked with you about alcohol use?				
Male	6.0	2.2	1.8	89.7
Female	4.6	1.4	0.8	92.9
6. Has a doctor or other health professional ever advised you to quit smoking?				
Male	51.3	8.3	13.3	27.1
Female	60.8	11.8	6.2	20.6
7. Has a doctor or other health professional ever talked with you about your sexual practices?				
Male	7.3	1.6	0.9	89.6
Female	12.2	4.4	2.7	80.3
		Yes	**No**	**Unknown/ Refused**
8. To lower your risk of developing heart disease or stroke has a doctor advised you to eat fewer high fat or high cholesterol foods?				
Total		40.2	59.4	0.4
Male		39.6	60.1	0.3
Female		40.7	58.8	0.5
9. To lower your risk of developing heart disease or stroke has a doctor advised you to exercise more?				
Total		39.8	59.9	0.3
Male		38.5	61.2	0.2
Female		41.0	58.8	0.3

(Note: Over 90 percent of respondents indicated one or more regular sources of care, and over 80 percent had "a routine check-up" within the last two years. Question 6 was asked only of current adult smokers. Each of the others was based on the entire sample of Oklahoma adults.)

million Americans are under treatment for alcoholism.[12] Even among nondependent users, alcohol abuse results in numerous adverse health consequences, such as cirrhosis, hypertension, cancer, pancreatitis, neuropathy, cardiomyopathy, and dementia. Nationally, alcohol abuse is associated with a high proportion of traffic fatalities (41%), drownings and murders (67%), deaths in fires (70-80%), and suicides (35%). It also contributes to domestic violence, depression, divorce, unemployment, and poverty. An estimated 1 in 3,000 births are affected by fetal alcohol syndrome each year.[5]

In Oklahoma, one area in which alcohol's impact is most striking is its relationship with our inordinately high morbidity and mortality from unintentional injuries. For example, in 1997, alcohol was implicated in a total of 9,444 motor vehicle injuries with 200 fatalities statewide. Also, over one third of all spinal cord injuries in our state are linked to drug or alcohol use.[13]

The USPSTF is clear in its recommendations concerning alcohol: All adult and adolescent patients should be screened to detect problem drinking, and patients with evidence of alcohol abuse or hazardous drinking should be offered brief advice and counseling. Counseling should involve feedback of the evidence of a drinking problem, discussion of the role of alcohol in current medical or psychological problems, direct advice to reduce consumption, and plans for regular follow-up.

The *Guide* recommends that screening involve a careful history of alcohol use. Ask patients about the quantity, frequency, and pattern of their drinking. Asking about tolerance (e.g., "How many drinks can you put away without it affecting you?") may help to circumvent denial. Several instruments can be administered by office staff to augment your history. Probably the simplest is the CAGE questionnaire (see Figure 1). Any "yes" answer on that questionnaire should prompt further assessment for alcohol-related problems.

Table 2 indicates that Oklahoma physicians are doing poorly when it comes to assessing patients for problem drinking; only about 10% of Oklahomans recall any health professional ever inquiring about their use of alcohol (see question 5). Perhaps we have been lulled into a false sense of complacency when it comes to counseling about drinking. According to the 1997 Oklahoma BRFSS survey, two-thirds of Oklahomans denied any use of alcohol within the month in question. However, among those Oklahomans that do drink, heavy drinking is quite prevalent: over 35% of male and 15% of female alcohol users consume more than five drinks per day in a randomly selected month. Consequently, asking focused alcohol-related questions may help to identify at-risk patients before they experience significant physical or social morbidity.

C: Have you ever felt you ought to CUT down on your drinking?
A: Have people ANNOYED you by criticizing your drinking?
G: Have you ever felt bad or GUILTY about your drinking?
E: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (EYE opener)?

Figure 1. CAGE questionnaire for assessment of alcohol abuse

Oklahoma clinicians can help decrease the morbidity and mortality from alcohol in our state. Research indicates that detecting early problem drinkers and intervening with brief counseling interventions can reduce alcohol consumption and improve clinical outcomes.

Safety Messages-Preventing Injuries

Injuries exact a huge toll on our state. Each year approximately 1,500 Oklahomans die from unintentional injuries, with another 450 from suicides and 275 from homicides.[13] Injuries are the third leading cause of death for all age groups (behind heart disease and cancer), but the leading cause of death and lifelong disability among persons 1 to 44 years of age. It is estimated that over 25,000 Oklahomans are hospitalized each year from an injury. Moreover, the injury death rate in our state exceeds the national rate by 24%.

Traffic deaths are the leading cause of injury death in Oklahoma, accounting for nearly 700 deaths annually and 32% of all injury deaths. The other leading causes of injury death include suicide (22%), homicide (13%), falls (8%), fires/burns (4%), drugs/poison (3%), and drowning (3%).

The effectiveness of occupant restraints (lap/shoulder belts and child safety seats) in preventing motor vehicle fatalities is well established. The National Highway Traffic Safety Administration reports a 45% decrease in fatal front seat injuries when lap and shoulder belts are used properly.[14] The benefit is even greater for light truck occupants, where the risk of fatal injury drops 60%. Infants and toddlers in child safety seats experience a similar level of fatali-

ty risk reduction (47 to 69%).

However, these facts seem lost on many Oklahomans. Safety belt usage in our state is below the national average; in 1996, only three states had lower seat belt usage rates than Oklahoma. A 1998 statewide observational survey revealed that only 56% of adults wore seat belts[15] and only 54% of infants and children were restrained in safety seats.[16]

Wearing helmets while riding motorcycles or bicycles is another important prevention message that should be heard in our offices and clinics. During the five-year period 1993-1997, 325 Oklahomans suffered traumatic brain injury due to bicycle riding (23 fatal). The majority of these injuries could have been prevented had the person worn a helmet, a practice that reduces the risk of nonfatal head injury by an estimated 85% and fatal brain injury by 88%.[17] Counseling bicycle riders (or their parents), appears to have a positive influence on helmet use.[18]

Other important safety messages that can be delivered quickly include the importance of fire alarms, not drinking and driving, the potential danger of firearms in the home, and how to contact local poison control centers.

Improving on injury prevention counseling should be a priority for Oklahoma physicians. Not only do injuries exact a tremendous toll of death and suffering, they are also conditions for which simple recommendations delivered in the doctor's office (such as the importance of wearing a seat belt) can have significant benefit. However, Table 2 indicates that physicians are perceived as virtually mute when it comes to injury prevention. Only about 10% of Oklahomans recall a health professional ever speaking to them about these important issues (see question 3). This is an area we should strive to improve.

Counseling to Promote Exercise and a Healthy Diet

Two areas that have tremendous impact on a person's health are nutrition and physical activity. Major diseases in which diet plays a role include coronary heart disease, stroke, hypertension, obesity, non-insulin dependent diabetes mellitus, and cancer of the breast, colon, prostate, and lung. Physical activity and fitness have been shown to reduce morbidity and mortality for at least six chronic conditions—coronary heart disease, hypertension, obesity, diabetes, osteoporosis, and mental health disorders. These are especially important issues for our state when we realize that obesity may be the second leading cause of preventable death in the U.S. (after tobacco), and it is estimated that almost 30% of the adult population in Oklahoma (970,000 persons) are severely overweight.

Although the benefits of a healthy diet and regular physical activity have been clearly documented, there is insufficient evidence at present that brief counseling by physicians is effective in changing dietary and exercise habits of patients. Nonetheless, physicians should still continue to deliver the appropriate messages concerning these issues, and provide more in-depth information and make referrals when indicated. The current USPSTF recommendations for these behaviors are as follows:

Promoting a Healthy Diet: Adults and children over age 2 should limit dietary intake of fat (especially saturated fat) and cholesterol, maintain caloric balance in their diet, and emphasize fruits, vegetables, and grain products containing fiber. Adolescents and adults, in particular, should reduce total fat intake to less than 30% of total calories and dietary cholesterol to less that 300 mg/day. Saturated fat consumption should be less than 10% of total calories. To achieve these goals, patients should emphasize consumption of more whole grain products and cereals, legumes, vegetables, and fruits. For animal products, better choices include fish, poultry prepared without skin, lean meats, and low-fat dairy products. Studies suggest that coronary heart disease mortality rates in the U.S. could be decreased by 5-20% if all Americans restricted their fat intake to less than 30% of total calories.[19]

Although physicians can often provide general guidelines on proper nutrition, many lack the time and skill to obtain a thorough dietary history and provide detailed recommendations. It is possible, however, that physicians can overcome these limitations by simply emphasizing the health benefits of good nutrition, providing expanded written information to patients, and referring those who need more intense counseling to other providers with greater nutrition expertise.

Promoting Physical Activity: Counseling to promote regular physical activity is recommended for all children and adults. This recommendation is based on the proven efficacy of regular physical activity in reducing morbidity from several chronic diseases. The physician should determine each patient's activity level, ascertain barriers specific to that individual, and provide information on the role of physical activity in disease prevention.

Although direct evidence is limited that clinician counseling can increase physical activity of asymptomatic patients, given the sizable risk for impaired health in sedentary individuals combined with the large population at risk, even modest increases in physical activity levels could have great public health impact. Maintaining fitness by participating in moderately vigorous physical activity can decrease mortality from coronary heart disease by 40-50%.[20-21]

Folic Acid for Prevention of Neural Tube Defects

Neural tube defects (NTDs), including anencephaly, encephalocele, and spina bifida, account for substantial morbidity in the U.S., occurring in 7.2-15.6/10,000 live born and stillborn infants.[22] Provisional data from the Oklahoma Birth Defects Registry for 1994-96, estimated that about 50 NTD cases occur each year in the state. The emotional and financial cost of these cases is devastating to affected families.

A personal or family history of a pregnancy affected by NTD is associated with an increased risk of NTD in future pregnancies, but about 90-95% of all cases have no identifiable risk factor.[23-24] Numerous studies have documented the efficacy of folic acid supplementation in reducing the risk of NTDs, both for recurrences[25-26] and in women without a prior affected pregnancy.[27-30] Because of the efficacy of the intervention and the fact that half the pregnancies in the U.S. are unplanned,[31] the USPSTF recommends that all women of childbearing age who are capable of pregnancy take a daily multivitamin containing 0.4 mg of folic acid to reduce the risk of NTD.

Women with a previously affected pregnancy who are planning another pregnancy should increase their folic acid intake to 4.0 mg/day,* beginning one month before and continuing through the first three months of pregnancy (this requires a prescription).[3] It is estimated that low-dose supplementation of all women capable of pregnancy would reduce the incidence of NTDs in the U.S. by 50%.[32] This effective and easily implemented preventive intervention should be a routine recommendation for all women of childbearing age in Oklahoma. Data from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based survey of Oklahoma women with a recent delivery, revealed that of 4,117 women surveyed in 1997, only 28% were taking a daily multivitamin one month prior to pregnancy.

Folic acid is also receiving increased attention in another area of disease prevention. There is growing evidence that folic acid may decrease the risk of heart disease and stroke, possibly by lowering blood levels of the amino acid, homocysteine.[33, 34]

How Much Time Does it Take?

Researchers at Case Western Reserve School of Medicine timed the services recommended by the Guide during actual patient encounters. The average cumulative time required to deliver the three primary counseling interventions discussed in this paper (tobacco, alcohol and safety belt use) was less than two minutes.[35] Others have reported that by spending an extra four minutes per patient on a single occasion, physicians can begin to implement a program of clinical preventive services that results in high rates of patient acceptance.[36]

Conclusions

Recent prevention research suggests that simple physician-delivered messages can have an impact on the major causes of morbidity and mortality in Oklahoma. Particularly important are efforts to decrease the adverse health affects related to smoking, alcohol abuse, and unintentional injuries (especially related to motor vehicle crashes). Physicians should also promote good nutrition and physical activity and recommend a daily multivitamin containing folic acid for all women of childbearing age. Indeed, Oklahoma physicians have the opportunity to improve the health of our citizens by making a small investment of time to encourage healthy behaviors. Of course, the messages will be most convincingly delivered if we are role models of the behaviors we advocate.

Should busy practicing physicians concern themselves with prevention activities? Some might argue that prevention should not be the responsibility of clinical medicine, that it belongs to public health and preventive medicine specialists. However, all health-care professionals should always attempt to intervene in disease processes as early as possible, since this almost always results in the best outcomes for

* Women taking drugs that interfere with folate metabolism (e.g., methotrexate, pyrimethamine, trimethoprim, phenytoin), women at increased risk of vitamin B-12 deficiency (e.g. vegans or persons with AIDS), and those with epilepsy whose seizures are controlled by anticonvulsant therapy, should consult with their clinician concerning possible risks and benefits prior to considering high-dose folic acid supplementation.

patients. Prevention is merely early intervention, utilizing the most current medical knowledge to intervene in disease processes at the earliest point, or, preferably, even before disease onset. Physicians are therefore practicing state-of-the-art medicine when they utilize prevention in the care of their patients. This sentiment was expressed by one of the world's most well known clinicians, William Osler, when he said, "Prevention is the highest form of medicine we can practice."

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PHYSICIANS' CAMPAIGN FOR A HEALTHIER OKLAHOMA

Please use the accompanying Patient Handout to distribute to your patients.

If you would like more information about the Physicians' Campaign for a Healthier Oklahoma, please contact Joy Leuthard, OSMA's Director of Health Care Policy and Research, at 405/843-9571 or 1-800-522-9452.

Quitting Tips

Getting Ready to Quit

Take stock of where you are now:

1. Talk with your doctor about your interest in quitting and find out about the treatments available to you.
2. Ask your doctor about your personal health risks due to your tobacco use, and work together to plan the quit method that's right for you.
3. Keep an open mind to information that supports your healthy decision. Read and listen to information on the hazards of smoking, the benefits of quitting, and the quit tips that have worked well for others.
4. Write down a list of the benefits you'll experience when you quit. Keep your list handy and keep it growing, even if you're not ready to quit right now.
5. Become aware of the things that trigger you to smoke, and plan ways to deal with those triggers when you quit.

Prepare to Quit

1. Set a quit date – keeping in mind the routines and situations that will help you succeed.
2. Get support from family, friends, or others who are quitting smoking. Be clear about what types of help you want and need, as well as what would NOT be helpful to you.
3. Sit in non-smoking sections of restaurants, and choose activities in smoke-free facilities.
4. Practice breathing deeply to manage small stresses through the day.
5. Delay or skip your first usual cigarette of the day.
6. Cut back on the number of cigarettes you smoke each day until you reach your quit date.
7. Quit for 24 hours

Quitting!

1. Use the 4 D's to help you cope with cravings:
 Delay – the urge will usually pass after a few minutes
 Deep Breathe – and use the time to relax
 Drink Water – and think of flushing the toxins from your body
 Do Something Else – such as:
 - Discuss with a friend or support person
 - Go for a walk or do other exercise
 - Do something with your hands such as gardening, household repairs, fidgeting with a rubber band, filing your fingernails, painting, etc.
 - Cook some healthy snacks
 - Chew on a straw
 - Play cards
2. Continue to build and recall your list of good reasons or benefits of quitting.
3. Reward yourself for resisting people, places, or things that trigger you to smoke.
4. Pay yourself for the cigarettes you don't smoke.

If you smoke again

1. Don't give up!
2. Learn from what went wrong
3. Get back to your plan
4. Get support

On behalf of the Oklahoma State Medical Association's
Physicians' Campaign for a Healthier Oklahoma and your physician

We wish you well!

Patient Handout #2

Willing to Die for a Cigarette?

- 468,000 deaths per year are caused by smoking, the single leading lifestyle factor that produces mass killing (20 times more than drugs).
- 25% of all smokers die prematurely from smoking-induced illness, with an average of 21 years of life lost.
- 54% of young smokers (aged 12-18) expect to be able to stop smoking in a year; 75% are unsuccessful
- Lung cancer is the leading cause of cancer death of men and women in the U.S.
- Smokers have an average of 30 times greater risk of dying of lung cancer before age 65 as non-smokers.
- Tobacco product use also increases the risk of many other types of cancer including the following: lip, mouth, throat, voice box, windpipe, esophagus, stomach, bladder, colon, cervix, skin, and blood (leukemia).
- 30%-40% of all coronary heart disease deaths in the U.S. each year are smoking related.
- Smoking substantially increases the risk of stroke and peripheral vascular disease.
- Smoking causes 85,000 deaths per year from lung disease, primarily emphysema.
- Maternal smoking has been lined to increased risk of tubal pregnancy, low birth weight babies, infant deaths, respiratory infections, asthma, impaired thinking, increased miscarriage rate, and other developmental abnormalities.
- Second-hand smoke causes major health problems for the families, friends, co-workers, and associates of smokers.
- Smokers tend to have reduced bone strength and more fractures, greater risk of back pain and injuries, hormonal abnormalities, more rapid loss of physical capability, accelerated skin wrinkling, accelerated hair loss and graying, accelerated loss of vision, difficulty sleeping, heartburn problems, and more cases of ulcers.

Remember . . .

It's your health, your life – and your choice!

(And if you believe the state's tobacco settlement money should go for the purpose for which it was intended – for programs for prevention, cessation, treatment of tobacco-related diseases, and research – please contact your state legislator and make your voice heard.

Patient Handout #2

A Curriculum for Stimulating the Moral Imagination

Jerry B. Vannatta, MD; Ronald Schleifer, PhD

Introduction

Literature has been used for many years as a method of teaching and learning medicine. An informal survey in 1994[1] found approximately one-third of American medical schools teaching literature to their medical students. The majority of these courses were elective.

Literature offers several advantages to teaching the humanism of medicine. Narrative knowledge allows the reader to experience vicariously the ill person's perspective. Excellent narrative presents the patient's experience in vivid and expansive detail, provoking the reader's moral imagination. Stories provide the reader-physician or medical student a context through which to analyze ethical issues. Literature, such as detective stories,[2,3] teach a method of logic helpful in the hypothetical-deductive process of diagnosis. These stories also portray mistakes in logic of solving the crime, analogous to mistakes made in the diagnostic process.

This paper discusses a curriculum taught at the University of Oklahoma, Undergraduate Honors College as a colloquium. The course was taught by Dr. Vannatta, a physician, and Dr. Schliefer, a literature professor and semiotician. Twenty-three students were enrolled, of which 19 were pre-med majors.

Previous Work

Robert Coles, in his book, *The Call of Stories*,[4] articulates through personal experiences with students at Harvard how narratives challenge the moral imagination of students. His work eloquently describes the value of a literary education to the moral development of the student. Among his many descriptions he relates stories used to teach lessons to medical students as well as students of the liberal arts.

Rita Charon, MD, in a 1995 *Annals of Internal Medicine* article[5] provides a clear and comprehensive discussion of how narrative works to teach humanism and ethics in medicine. Dr. Charon also describes literary theory and its relationship to reading and comprehending medicine from both the patient's and physician's perspectives.

Wilson and Blackwell[6] describe a two-week elective course in literature at Wright State University. This course combined interviewing patients and reading literature (novels, short stories, and poems), followed by small group discussions.

Rudway and Adelson[7] describe a Great Books Course to teach medical ethics. This course utilized multidisciplinary faculty. The students read great works of literature and used them as springboards of discussion of medical ethical issues.

This is but a small sampling of the published literature describing this field of interdisciplinary work between literature and medicine.

Course Description (Literature and Medicine)

The course was offered as a full semester colloquium in the Undergraduate Honors College at the University of Oklahoma. The authors designed the curriculum and taught the course. Twenty-three students enrolled, 19 of which were pre-med students.

The course consisted of 15 weeks of instruction. Each week was assigned one or two themes regarding a medical issue.

This course was organized around the central idea that the History of Present Illness (HPI) is the most powerful diagnostic test available to patient and physician. The History of Present Illness and literary narrative are similar in many

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Table 1. Reading List

Week	Theme	Reading List	Author
1.	Introduction/Diognostics		
	History of Present Illness	History ond Physicol Examinotion	Professor Vonnotto
		Systemic Norcotizing Vosculits	Horrison's Text Book of Medicine
	Systemic Lupus Erythemctosis		Horrison's Text Book of Medicine
2.	Illness	Diobetes -	Jomes Dickey
		excerpt: *Mogic Mountoin* -	Monn
		excerpt: *Modom Bovory* -	Floubert
		Indion Comp -	Hemingwoy
	Arrogonce/Doctor-Potient Relotionship	*The Doctor* -	The Movie
		The Artificiol Nigger	Flonnery O'Conner
		The Girl with the Pimply Face	Williom Carlos Willioms
3.	Potient Suffering: AIDS	*AIDS ond Its Metaphor*	Suson Sontog
		Porphyrio's Lover	Ferrol Soms
4.	Domestic Violence	*The Woman Who Walked Into Doors*	Roddy Doyle
5.	Interpretotion	*Dora*	Sigmond Freud
		The Country Doctor	Fronz Kufko
6.	Mumpsimus	Essoy	Scorlett
		The Color Blind Painter	Oliver Socks
	Experience ond Interpretotion	*The Lady with the Pet Dog*	Anton Checkov
		The Lady with the Pet Dog	Joyce Corol Ootes
7.	Professionolism ond Responsibilities	*Epiphany*	Ferrol Soms
		Old Doc River	Williom Corlos Willioms
		The Practice	Williom Corlos Willioms
	Alcoholism	*Hey Soilor What Ship*	Tillie Olsen
		Alcoholics Anonymous	Anonymous
8.	Doctors ond Fomilies	*Tender Is The Night*	F. Scott Fitzgerold
9.	Sexuol Abuse	*Bostard Out of Carolino*	Dorothy Allison
10.	Deoth ond Dying	The Corrioge held but just ourselves	Emily Dickinson
		Do Not Go Gently into Thot Cruel Night	Dylon Thomos
		The Deoth of Ivan Illych	Leo Tolstoy
11.	Birth	*The Birth*	Williom Corlos Willioms
		Dead Boby	Williom Corlos Willioms
		Beloved (p78-85)	Toni Morrison
		Apostrophe, Animotion, ond Abortion	Borboro Johnson
	Doctoring	*Out of My Life and Thought*	Albert Schwitzer
		First Word	George Bernord Show
12.	Medicol Life	*Arrow Smith*	C. S. Lewis
		Poid Nurse	Williom Corlos Willioms
13.	Heolers	*Mobey Dick*	Hermon Melville
		The Doctor ond the Devil	Dylon Thomos
		Doctor's Dilemmo	Bernord Show
		Delusions	Bernord Show
14.	Quacks ond Clowns	*Surgical Word*	W. H. Auden
		The Interior Costle	Jeon Stofford
		The Injury	Williom Corlos Williams
15.	Empothy Development	*Beloved*	Toni Morrison

ways. The nature of the HPI is an oral history in narrative form given by the patient. The physician listens, facilitates, and clarifies the details. The narrative is then written by the physician as a somewhat transformed version of the patient's narrative. The product of an excellent HPI is much like the rich texture of a great short story. We have taken advantage of these similarities as we have the students approach the literature, and consider the many stories patients will provide in the clinical encounter.

The goals of the course, therefore, were to: 1) import an understanding of the History of Present Illness; 2) understand narrative knowledge; and 3) explore 15 medically related themes through reader-response method, followed by in-class discussion.

Students were assigned the readings, wrote a one or two page response to each reading, and participated in class discussions regarding the

reading, the themes, and the student responses. Table 1 lists the weekly themes and readings lists.

A real patient history and physical examination was read in the first week. This was to explore how the physician records narrative in the diagnostic process. An Arthur Conan Doyle story demonstrated the diagnostic process and logic used by the detective. Analogies between the physician's narrative and diagnostic process and those of Sherlock Holmes were explored.

The doctor-patient relationship was explored through the movie, *The Doctor*. Students responded to the various roles the physicians played in the movie. Issues such as empathy, listening, and caring were demonstrated and discussed.

The grandfather in Flannery O'Connor's *Artificial Nigger* demonstrates arrogance and provides an excellent example for discussion. Reading this short story in the same week as watching *The Doctor* allowed students to draw comparisons and approach many aspects of physician attitudes, behavior, and ethics.

Susan Sontag discusses the metaphorical nature of AIDS in *AIDS and its Metaphor*. This stimulated exploration of the metaphor, how it works, and provided a platform to search for metaphorical meaning in future readings. The discussion on illness as metaphors caused some students for the first time to consider the "meaning" personally placed on illnesses, and the "values" attached to illness scripts as revealed by patients.

Domestic violence is the theme of Roddy Doyle's powerful novel *The Women Who Walked Into Doors*. Alcoholism is also depicted. The students were surprised by their reaction to this book. Some students had never discussed domestic violence, and most were stunned to consider that a physician might ignore it, or accept a superficial incorrect response to questions in the emergency room. This opened a rich discussion in class of the quality of the information one may find recorded in the HPI.

Dora, Freud's first case report of "hysteria," created enthusiastic discussion. It is fair to say that students of the 90s are capable of recognizing his faulty logic and biased methods. Exploration of transference and counter transference stimulated new ideas for these students and led to marvelous discussions of ethics of doctor-patient relationships.

Anton Checkov and Joyce Carol Oates wrote different versions of the same short story and titled them identically—*The Lady With the Pet Dog*. An extramarital love affair is portrayed in this excellent story. It is seen as a male perspective in Chechov's version, and as that of a female in Oates' rewrite. Our class was approximately half male and half female. The discussion of gender perspectives was used to explore the influence of belief systems on interpretation of sense data. Discussion was intense, biases were revealed, and moral challenges made by many students.

Table 2. Samples of Students' Responses to the Course

Comments	Number of Students
Value of perceptions different from my own	6
Identification with situations outside my experience	5
Learned to develop empathy through stories	14
Challenged me to think	2
It taught me to listen carefully to someone telling me a story, whether it is a patient or a client in a business transaction	1
The course improved my writing skills	3
The course caused me to question my beliefs	1

Professionalism and responsibilities tied to previous discussions of the doctor-patient relationship were topics covered by Ferol Sam's *Epiphany*, William Carlos Williams' *Old Doc Rivers*, and his essay *The Practice*.

F. Scott Fitzgerald creates a situation where a physician, Dr. Diver, marries his patient after falling deeply in love with her in *Tender is the Night*. This work inspired discussion of physicians and their professional relationships to their own families. Dr. Diver's deterioration throughout the novel was disturbing to some students and impassioned personal responses in their writings.

Possibly the liveliest discussion of the semester came in relation to Dorothy Allison's novel *Bastard Out of Carolina*. This first person account of physical and sexual abuse is powerful. Most students had not considered this topic in any manner other than superficially. Written responses, including some in the form of an HPI, were astounding. Sensitivities were clearly heightened, and one could recognize empathy developing for the protagonist in the story, Bone.

Poems were periodically read to explore death, dying, birth, abortion, and doctoring. Students were asked to consider viewpoints other than their own regarding these topics.

The course concluded with a reading of Toni Morrison's novel *Beloved*. The students found the images in this story quite powerful, and several students related a new, and for some, a first-time connection with the idea of having been a slave. One student pointed out that reading the

novel clarified for her where the "Blues" came from. This form of music was about what men and women lost when forced into slavery. It was pointed out that the loss of sexual freedom and geographic freedom led the slaves to sing about "traveling" and "sex" in this musical expression. *Beloved* also helped some students appreciate the use of narrative to expand their experience of others' lives heretofore unimaginable. Many were surprised at the connection between this use of literary narrative and doctoring.

As demonstrated in Table 1, these are but a small sample of how the readings worked in the course. The authors' evaluation was that the reading pace was intense but appropriate for an honors curriculum.

Student Evaluations of the Course

At the conclusion of the course, each student was asked to write his or her evaluation of the course. They were asked to relate the course's strengths and weaknesses. Table 2 lists samples of the students' responses to the course.

Follow-up and Further Studies

Six students who were enrolled in this first Literature and Medicine OU course are now enrolled in OU Medical School. They have agreed to be interviewed periodically over their four-year medical school experience and share reflections they have on the effect of these works of literature on their medical school experiences.

This course will be continued in the undergraduate school, and methods of introducing it in medical school and postgraduate education are being explored. J

The Authors

Jerry B. Vannatta, MD, is executive dean of the College of Medicine and professor of Internal Medicine at the University of Oklahoma Health Sciences Center-Oklahoma City. Ronald Schleifer, PhD, is a professor in the English Department at the University of Oklahoma-Norman.

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Oklahoma State Medical Association

Continuing Medical Education

OSMA Accredited Institutions:

Deaconess Hospital - Oklahoma City

Duncan Regional Hospital - Duncan

Hillcrest Medical Center - Tulsa

Institute for Mental Health - Oklahoma City

Integris Baptist Medical Center - Oklahoma City

Integris Southwest Medical Center - Oklahoma City

Jane Phillips Medical Center - Bartlesville

Mercy Health Center - Oklahoma City

Norman Regional Hospital - Norman

Orthopaedic & Reconstructive Research Foundation - Oklahoma City

St. Anthony Hospital - Oklahoma City

Saint Francis Hospital - Tulsa

St. John Medical Center - Tulsa

Stillwater Medical Center - Stillwater

Valley View Hospital - Ada

Course offerings from OSMA Accredited Institutions

Integris Baptist Medical Center - Donna Schoenfelder - 405-949-3284

Feb. 4,18,25	Tumor Board	7:00am	1 hour
Feb. 11	Cancer Conference	7:00am	1 hour
Feb. 14	Cause of Death Determination	7:00am	1 hour
Feb. 18	Autopcy CPC-TBA	Noon	1 hour

Mercy Health Center - Debbie Stanilla - 405-752-3806

Feb. 03	The Affliction: Domestic Violence	12:15pm	1 hour
Feb. 10	Treatment of Incontinence in the New Millennium	12:15pm	1 hour
Feb. 15	Neurscience Inst. Lecture Series	7:00am	1 hour
Feb. 17	Aggressive Lipidmanagement	12:15pm	1 hour
Feb. 24	Systemic Inflammatory Response Syndrome Update	12:15pm	1 hour

Southwest Medical Center-Integris - Jonathan Stotler - 405-636-7087

Feb. 02	Depression	12:15pm	1 hour
Feb. 09	Medical Ecomonics of Allergic Rhinitis	12:15pm	1 hour
Feb. 16	Stroke Management	12:15pm	1 hour
Feb. 23	Osteoporosis Update	12:15pm	1 hour

St. Anthony Hospital - 405-272-6358

Feb. 07	Cardiovascular Disease & Hypertension Therapies	8:00am	1 hour
Feb. 21	Skin Cancer	8:00am	1 hour

St. John Medical Center - Gail Hilst - 918-744-2875

Feb. 01	Critical Care Conf.: Hypertensive Emergencies	Noon	1 hour
Feb. 03	Critical Care Conf.: Parathyroid Disorders	Noon	1 hour
Feb. 08	Critical Care Conf.: Acute Pancreatitis	Noon	1 hour
Feb. 10	Critical Care Conf.: Hepartorenal Syndrome	Noon	1 hour
Feb. 15	Critical Care Conf.: Subarachnoid Hemorrhage	Noon	1 hour
Feb. 17	Critical Care Conf.: Pre-Eclampsia/Eclampsia	Noon	1 hour
Feb. 18	Critical Care Conf.: Heparin Induced Thrombocytopenia	Noon	1 hour
Feb. 22	Critical Care Conf.: Thoracoabdominal Aneurysms	Noon	1 hour
Feb. 24	Critical Care Conf.: Case Review	Noon	1 hour
Feb. 29	Critical Care Conf.: Improving Outcomes in ICU	Noon	1 hour

Valley View Regional Hospital - Belinda Runnells - 580-421-1467

Feb. 29	New Treatments for Asthma	Noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator, at 405-843-9571.

PRACTICE MANAGEMENT

AMA Litigation Center Pushes for Physician Rights

Linda Scoggins, Esq.

In December, I attended an interim meeting of the American Society of Medical Association Counsel (ASMAC) in San Diego. ASMAC is a unique legal organization in that it consists of lawyers whose central task is representing organized medicine. Primarily, but not exclusively, members are employed by medical societies throughout the United States, national, state, local and specialty societies. ASMAC's primary purpose is to provide a network through which members can share ideas and documents in order to better represent organized medicine.

Although not unexpected, the meeting confirmed that the problems faced by Oklahoma physicians are not unique to this state. A roundtable discussion among members addressed problems with managed care, hospital/physician relationships, fraud and abuse compliance, confidentiality regulations, National Practitioner Data Bank issues, telemedicine, and the viability of a national panel of court-appointed experts, among other issues.

The underlying issue with respect to managed care appears to be the unequal bargaining power of the managed care organization vis a vis the physician. Initiatives are being undertaken by the American Medical Association (AMA) to assist physicians in challenging managed care contracts. For example, the group discussed the AMA's challenges to "all products" clauses in managed care contracts as well as to clauses which allow termination of providers without cause. Managed care companies' antitrust violations, possible collective negotiations legislation, and HMOs' attempts to challenge external review as being pre-empted by ERISA were also discussed.

With regard to fraud and abuse, the need for physician compliance plans was discussed in length. Concern was expressed for the costs involved in implementing a physician practice compliance program versus the practical benefit a compliance program provides the physician. OSMA's outline for development of a compliance program was offered as an example of what a medical society can do to assist its members in this area.

ASMAC members also attended the membership meeting of the Litigation Center of the American Medical Association and state medical societies. The Litigation Center is actively supporting physicians in state and federal courts across the country. Cases and/or issues being addressed by the Litigation Center include opposition to the extension of liability to physicians under novel legal theories (i.e., breach of fiduciary duty), opposition to any religious exemption provisions in child abuse and neglect laws, support for the confidentiality of peer review proceedings, fighting health insurers' attempts to secure unwarranted discounts on physician charges through silent PPOs or other schemes, opposition to hospital efforts to use staff credentialing decisions to gain or maintain an economic advantage as opposed to credentialing decisions based on the applicant's ability to provide quality patient care, opposition to third-party payor's unilateral changes to contracts with physicians, support of state regulation of HMOs that benefits patients, opposition to arbitrary terminations of physicians by managed care organizations which unduly disrupt the physician-patient relationship, and protection of physicians who face de-selection because they recommend proper care for their patients.

The Litigation Center members also heard a report on the class action lawsuits against insurers currently pending in federal district court for the Southern District of Mississippi. (Same court with jurisdiction over the successful tobacco litigation) The defendants in these national class

action suits are Aetna, Prudential, Pacificare, Cigna, Humana and Foundation. These class actions allege wrongdoing on the part of the insurers under the RICO statutes. RICO stands for Racketeer Influenced and Corrupt Organizations Act. Basically, the plaintiffs claim that the insurers have committed underlying crimes by interfering with delivery of medical services and exerting severe pressure on physicians amounting to extortion. The class actions also claim that HMOs have fiduciary responsibilities under ERISA. At this time, the Litigation Center's role in the class actions is only to have dialogue in order to formulate a position.

The Litigation Center sees the upside to these class action lawsuits as being the fact that they are very powerful tools to affect change. The Litigation Center also believes that such class action lawsuits; may facilitate working with attorneys general on potential actions against HMOs and in the passage of legislation to assist physicians in dealing with managed care organizations. However, the Litigation Center is well aware of the downside to these class action lawsuits. There needs to be a clear focus as to which cases are appropriate for the medical community to support. The medical community should not want to support novel legal theories that might come back to bite physicians, i.e., fiduciary relationship theories. Thus, before camaraderie is established between the Litigation Center and the plaintiffs' lawyers in these class actions, research and discussion will be comprehensive and will involve an interdisciplinary team of physicians and attorneys.

It was apparent at the December meeting that the AMA and the Litigation Center are actively involved in advocacy for physicians at both the state and federal levels, judicially and legislatively. There is a general recognition that the tide must be turned to support physicians in their day-to-day battles with insurers, regulators, etc.

The Author

Linda Scoggins is a director and shareholder in the law firm of Hartzog Conger & Cason, based in Oklahoma City. Her practice is limited to areas of health law, employment law and litigation. Hartzog Conger & Cason, a firm of 23 lawyers, acts as General Counsel to the OSMA.

THE CONNECTED CLINICIAN

The Economy of Medical Knowledge

Chris Candler, MD

For over three centuries the information needs of physicians have been met by print materials in the form of books, journals, and other physical media. Even now, at the dawn of a new millennium, clinicians continue to rely on the printed pages of books and periodicals; very little has changed in the world of scholarly communication, even in the face of the information revolution.

During the 1970s the Internet emerged as a global network capable of rapidly distributing large amounts of information across oceans and continents. The technologies of word processing and the World Wide Web have revealed that digital documents can be more dynamic than their printed brethren and less at risk for irrelevance and obsolescence. And while the printed publication has always been relatively resource-intensive to produce and distribute, online documents may be disseminated at minimal or no cost.

Besides the potential for universal access and negligible cost, online publications also have the capacity to incorporate various multimedia such as dynamic graphs, sounds, video, and animations. In addition, online documents may be hyperlinked to one another such that a citation is only one click away.

If these decades-old technologies have provided unparalleled opportunities to disseminate knowledge, then why hasn't clinical and scholarly communication fundamentally changed? The real issue lies deeper than better access and pretty pictures; it concerns biomedical information as a commodity.

In 1665 the first real scientific journal was published by the Royal Society of London as a means to disseminate its members' research. In the centuries that followed, scholarly journals became an effective vehicle to propagate knowledge among the scientific community. Before World War II, most scientific journals were published by scientific societies whose members' dues largely paid for publication costs. During the postwar boom the number of scientists and research dollars proliferated, attracting commercial publishers to this previously ignored market. Gradually, biomedical information was transformed into a highly regarded commodity, the prodigious offspring of marriages between professional societies and commercial publishers.

Depending on which side of the fence you're on, this commercialization has either enhanced or inhibited the indispensable flow of clinical knowledge. But one thing is for certain: the cost of this commodity has risen... significantly.

The skyrocketing cost of scholarly journals has escalated to the point that the situation is now commonly referred to by librarians as the serials crisis. Since 1986, the 121 Association of Research Libraries (ARL) members spent 124 percent more on serials to purchase 7 percent fewer titles. Libraries across the country are canceling longtime subscriptions so that they may retain their most essential titles. This widening gap between the cost of scholarly information and available funding has spurred the formation of such groups as the Scholarly Publishing and Academic Resources Coalition, or SPARC, a forum to identify alternatives to high-priced publications.

But is the printed journal or book the most efficient economic unit of information? Do clinicians read books and journals or do they read sections and articles? Online technologies have the potential to customize and deliver information in the format, time, place, and level of detail that best meets the clinician's needs. Publishers have discovered personalization opportunities with online technologies and have initiated pay-per-view pricing structures. Furthermore, publishers have formed curious alliances with one another and with commercial portal sites.

It is quite common for medical web sites to lure viewers with full-text journal articles, practice guidelines, and reference resources so that they may present advertisement banners and build strategic relationships. Thus even on the open frontier of the Internet, medical knowledge exists as a commodity.

If medical knowledge is inevitably a commodity then is universal, commercial-free access possible in a market-driven global economy? While this question remains to be answered a landmark NIH project is a nod in that direction. PubMed Central (originally called E-biomed) plans to publish free full-text articles submitted by both scientific societies and commercial publishers through two separate archives: a peer-reviewed archive and a non-

reviewed archive. Immediately, this radical project polarized the scientific publishing community.

Scores of publishers have lambasted the plan as complex, unnecessary, and ambiguously governed. Not surprisingly, a recent survey revealed that an overwhelming 95 percent of respondents agreed that medical journals should offer their articles for free through PubMed Central. A somewhat silent benefit to this kind of a public archive is a new paradigm for intellectual property as authors may retain ownership of their efforts in many instances.

This kind of endeavor is not unique to biomedicine as many disciplines have started open peer-reviewed research archives such as CogPrints (cognitive sciences), NCSTRL (computer sciences), RePEc (economics), and LANL e-print (physics). The Open Archive Initiative has recently emerged as a forum to encourage interoperability standards among such public research archives. But, while online research repositories may reduce many of the costs of print publication, they are certainly not free and will require new funding mechanisms.

Proponents are quick to point out that these new costs represent only a fraction of the cost of traditional subscriptions. Obviously, the entrenched model of high-price, low-circulation publications is threatened by this new philosophy. Scholarly publishers are scrambling to form partnerships and develop electronic versions of their documents. But cost recovery isn't easy on the Internet where so much is available for free (and often expected to be).

The advent of the Internet has served as a change agent for many disciplines and industries. As with any paradigm shift, there are hard questions. Will the medical community ultimately reject established publishers to disseminate medical information and turn instead to open research repositories? The technology pundit Stewart Brand is credited with the assertion that " information wants to be free." It is both an opportunity and a threat, but is this vision of a freely available virtual public library realistic?

Opponents argue that such open repositories will suffer in terms of quality, consistency and prestige that well-known journals have delivered for years. Moreover, the organizations and individuals heavily invested in the current culture and economy of medical publishing are not likely to turn over their archives pro bono.

Change should be driven by a collaborative desire to improve access to knowledge and not by contempt for publishers.

It remains to be seen whether or not the transforming nature of technology will liberate or balkanize clinical and scholarly communication. Though the Internet is blurring the lines between producers, consumers, and distributors of information, it will not change the fact that knowledge, even medical knowledge, is a commodity to be bought, sold, and exchanged. And while technology propels us closer to the promise of universal access, throwing the publishing industry into spins and fits, it will not change the fact that this new digital commodity will continue to obey the established laws of economics as the commercial world seeks to personalize content and add value wherever possible.

But one thing is for certain, the clinician of the future will have more options to harness this information and bring the products of research and scholarship to the bedside.

The Author

Chris Candler, MD, is director of the Office of Educational Development and Research at the University of Oklahoma College of Medicine in Oklahoma City.

Editor Comments

Dr. Candler discusses the dilemma that confronts all users and producers of medical literature. It has been extremely useful to have access to medical literature without significant cost. It has been useful to be able to search the online sources of information in a timely fashion and have access to abstracts on critical material.

The timeline from publication to application has been shortened. Yet the same clinical dilemma exists...is the study a valid one, is it based on decent science or does this apply to clinical population for which I am providing care?

Those who write for publication have traditionally not been compensated directly. The cost incurred by most of the publication costs has been collected by the industry that has grown up around the science. The payment for the "science" is more indirect, the product of a grant, the improvement of a CV or the recognition and subsequent advantage that comes from that recognition.

I, for one, am extremely hopeful that this "revolution in medical publication" performs in a way to liberate our information needs, rather than restrict them. Is it time to publish the JOSMA online? These discussions are being considered. Will that change the motive of authors to write for our Journal? The future is not clear. If information allows you to provide improved care for your patients, then the answer is obvious...do what ever it takes to disseminate the information.

J. Michael Pontious, MD

Doctor's Diary

The Fabric of Oklahoma Medicine

Joe D. Haines Jr., MD

Practicing medicine in Oklahoma presents one with a wide variety of opportunity and exposure. Many physicians see the variety as a gift, threads woven into the fabric of Oklahoma life. We all have stories that remind us of the fabric.

Jack is one of those patients who always has a smile and a friendly word for the staff and for his physician. The sort of patient one looked forward to seeing. Jack had a severe weight problem. He usually tipped the scales between 400 and 500 pounds. Yet, he didn't let his morbid obesity interfere with his life. He owned his own company and was a devoted family man and church member. Although very devout, Jack was not the self-righteous sort.

In stark contrast, the preacher at Jack's church was known for being very narrow-minded and confrontational. He was definitely the anal-retentive type. The preacher had somehow become convinced of the virtues of coffee enemas and enthusiastically recommended them to all his parishioners.

Not long after this became known in our small town, Jack showed up for an appointment. Just before he left, the medical assistant couldn't resist asking him if he had taken the preacher's advice concerning the coffee enemas.

Jack unhesitatingly assured her that he was an affirmed convert, going into detail that could have been considered proprietary information.

Without missing a beat, the medical assistant shot back, "Well Jack, I've just got one question... Do you take yours black or with cream and sugar?"

Then there are the moments that catch one unprepared. Moments that couldn't have been scripted or even predicted.

She sat on the emergency room gurney in her father's arms, this precious four-year-old little girl with long blonde hair and bright blue eyes. As the emergency room physician, it is always good to have the chaos shattered by a little cherub, who for the moment becomes the patient.

It was a very busy night and we had five people lined up waiting to be seen in the eye, ear, nose and throat exam room. The little girl chattered away brightly and when I inquired of her father what problem brought her to the emergency room. He related to me that she had come downstairs during a party and entertained the guests by putting a peanut up her nose.

About this time the little girl turned to a middle-aged woman who was also waiting, and matter-of-factly inquired of her, "Did you put a peanut up your nose, too?"

Every emergency room in the country knows that the bars close at 2 a.m. There is a predictable "rush hour" as the drunks move from the dark, smoky barrooms to the bright, well-lit emergency rooms. I was just finishing up suturing a scalp laceration incurred when the patron of a local establishment suffered a blow to the head with a beer bottle. Fortunately for me, his combativeness had been overcome by the sedation of the alcohol. He snored softly and rhythmically as I sutured.

Even though it was the middle of the night, I enjoyed the job of putting my patient's head back together. I had studied the suturing techniques of skilled surgeons and worked vigorously to improve my ability. A lot of folks would probably not understand my 3 a.m. meticulous attention to detail as I sutured this intoxicated man's scalp back together.

As I finished the laceration and turned the patient over to the nurse, I heard a car door slam outside the ER. A horn began honking. I thought for a moment about the bed in the physician's call room, a bed that I would not be able to utilize for a while longer.

A frantic woman burst through the door and screamed, "My daughter is having a baby!"

One of the nurses calmly stepped up with authority and announced, "I'm sorry, but we don't do OB at this hospital. Where's your daughter's doctor?"

"Pawnee," answered the woman. Pawnee was 20 miles further down the road. "Well, you'll just have to go there," the nurse said with finality.

"But she's having the baby NOW!" the woman exclaimed.

I couldn't suppress a laugh as I listened to this conversation between two equally insistent women. I looked over at the nurse and said, "I think you'd better invite this woman's daughter inside and get ready for a delivery before she has the baby in the parking lot."

Now it was the nurse's turn to become a bit disoriented and frantic. Apparently, she had not attended a delivery in many years. It had been years since the little hospital had had a birth. The nurse scurried about the ER trying to locate the proper instruments while I performed a quick exam that confirmed the woman's predictions. The baby's head was crowning.

She was indeed having her baby "now."

As the confusion around me intensified, I slipped on a pair of gloves and easily delivered a term baby girl. The whole process seems so smooth when everything goes well. When complications present themselves this joyful experience can become pure hell. I'd forgotten how much fun a normal delivery could be as I presented the proud mother with her new daughter.

What a contrast, I thought as I drove home in the cool early morning air. One minute I was sewing up the scalp of a bar fight victim and the next moment I am helping to bring an innocent life into the world.

It is this diversity that captures my interest in the fabric of patient's lives, woven to cross my path.

The Author

Joe D. Haines Jr., MD, is a family physician in private practice in Perkins.

News

OU Develops Computer Training for Physicians

Is there a computer technician in the house? With computer technology revolutionizing the teaching and practice of medicine, large numbers of faculty and community physicians are eager to acquire or update their computer skills.

The University of Oklahoma Department of Family and Preventive Medicine has launched a project to address those needs. The department recently received a $525,000 grant from the U.S. Department of Health and Human Services to develop and implement computer training programs for its faculty and for community physicians participating in the department's research network.

The goal of the three-year project is to create a Web-based tutorial that can be used as a training tool by physicians across Oklahoma and beyond.

Principal investigator on the grant is department chair Dr. Steve Crawford. Laine McCarthy, clinical assistant professor, is the grant's project manager.

"This grant will allow the OU Department of Family and Preventive Medicine to be at the cutting edge of medical education and allow our faculty to provide state-of-the-art instruction to future Oklahoma physicians," Crawford said.

Today, most medical students are reasonably adept using computer technology, McCarthy said. But even physicians who completed their medical education and residency training during the past year years missed out on the intense immersion into the world of computers that young people now take for granted.

"We have a group of faculty physicians trying to teach students who came through the technology boom," McCarthy said. "Catching up with their students is a need we hear over and over again from our facility."

Initially, McCarthy and her staff will teach computer skills one-to-one to family medicine faculty members. Then, an interactive tutorial will be designed to address the learning styles and needs of physicians in general, she said.

Once the tutorial is developed, McCarthy and her staff will conduct a pilot test using community practitioners affiliated with the Oklahoma Physicians Research Resource Network, a program of the OU Department of Family and Preventive Medicine and the Oklahoma Academy of Family Physicians.

AMA Sets Leadership Conference

Attention all medical leaders. The AMA wants you in Miami Beach on March 25-28 for the 2000 National Leadership Development Conference. The conference will feature nationally acclaimed speakers and panel participants, including Tom Peters, PhD, acclaimed author of *In Search of Excellence*, and Ian Morrison, PhD, Senior Fellow, Institute for the Future and noted author and consultant.

Interactive break-out and optional sessions will encompass such topics as the Future Role of Medical Associations; How to Write a Speech; Media Interview Skills Update; Medical Practice Management; and Leadership Skill Building.

For registration information, call the AMA registration hotline at (800) 262-3211 or visit the NLDC Web site at www.ama-assn.org.

Phillips Named to Cancer Care Post



Cancer Care Associates has named David L. Phillips as executive director of the statewide private practice of physicians who specialize in cancer treatment and research.

Before joining Cancer Care Associates, Phillips was chief operating officer of WorkNet, a subsidiary of Community Care Managed Healthcare Plan of Oklahoma Inc.

Cancer Care Associates, a private practice founded in 1972, is a statewide network of 40 physicians who are specially trained in adult medical oncology, gynecologic oncology surgery, and hematology.

Video Conference on Asthma Management Planned

The second of two interactive video conferences titled "Improving Asthma Management in Oklahoma Schools" will be presented Tuesday, February 29, to ONE-NET sites throughout the state by the Oklahoma Commission on Children and Youth.

The first video conference was presented in January to Title 1 sites throughout the state.

The video conference will include short presentations by professionals who are involved in the management of asthma in school, with a question-and-answer session for site attendees.

Scheduled participants include: Santiago Reyes, MD, Pediatric Pulmonologist; Debbie Berry, RN, from the Cystic Fibrosis Center at Children's Hospital of Oklahoma; Dr. Lawrence Rossow, University of Oklahoma Professor of School Law; and Ivoria Holt, Oklahoma Health Care Authority, Medicaid Reimbursement Specialist.

Locations for the video conference are: Northern Oklahoma College-Tonkawa, Tonkawa; Yarbrough Public Schools, Yarbrough; Beaver Public Schools, Beaver; Kiamichi Tech Center, Idabel; University of Central Oklahoma, Edmond; Pontotoc Tech Center, Ada; High Plains Vo-Tech, Woodward; Southwestern Oklahoma State University, Weatherford; and Oklahoma State University-Tulsa, Tulsa.

For more information on the video conference, contact the Oklahoma Commission on Children and Youth at 405/522-4708.

New Standards Recommended for Women's Health Screening

The American College of Obstetricians and Gynecologists (ACOG) has made new recommendations for women's health care exams that include screening for hepatitis, diabetes, HIV, and urinary and fecal incontinence.

"Periodic assessments provide an excellent opportunity to counsel patients about preventive care," ACOG said in a report. ACOG provides recommendations on what types of screening, evaluation and counseling should be included in women's routine exams, based on patients' age and risk factors. The College's new recommendations replace those issued in 1997.

ACOG also recommends that doctors ask all patients about their use of complementary and alternative medicines in order to develop a more complete medical record and to encourage safe use of these products.

The College's recommendations still include an annual pelvic exam and Pap smear, beginning at age 18 or when sexually active; mammography every year or two for women in their 40s, changing to every year starting at age 50; and a first preventive care visit to an OB-GYN at age 13 to 15.

Although these recommendations are positive regarding preventive health care, some health care providers are concerned that they don't include the cessation of tobacco use.

Alzheimer's Report Available

Free copies of the National Institute of Aging's "Progress Report on Alzheimer's Disease, 1999," are available from the Alzheimer's Disease Education and Referral Center. The report can be obtained by calling (800) 438-4380.

Malcolm Horne, MD
1906-1999

Malcolm Horne, MD, died November 3, 1999. Dr. Horne was born on October 15, 1906, in Waco, Texas. He received his medical degree from the University of Oklahoma School of Medicine in 1946. Dr. Horne was a lifetime member of the Oklahoma State Medical Association.

Beverly Colvin Chatham, MD
1919-1999

Beverly Colvin Chatham, MD, died December 2, 1999. He was born on February 16, 1919 in Greenville, Kentucky. Dr. Chatham, a life member of the Oklahoma State Medical Association, received his medical degree from the Vanderbilt University School of Medicine in 1943.

Norman A. Cotner, MD
1927-1999

Norman A. Cotner, MD, a member of the Oklahoma State Medical Association, died December 3, 1999. He was born on March 28, 1927 in Booneville, Arkansas. Dr. Cotner received his medical degree from the University of Oklahoma School of Medicine in 1958.

Alan Knight Braly, MD
1950-1999

Alan Knight Braly, MD, died December 9, 1999. Dr. Braly was born on March 30, 1950 in Mooreland, Oklahoma. He received his medical degree from the University of Oklahoma College of Medicine in 1982 and was a member of the Oklahoma State Medical Association.

Wilson David Steen, PhD
1923-1999

Wilson David Steen, PhD, died December 12. He was born in Hugo, Oklahoma, on July 21, 1923. He received his master's degree in public health at Columbia University before receiving his doctorate degree from the University of Oklahoma Medical Center in preventive medicine and public health in 1963. Dr. Steen served as professor and head of the Community Health Division in the Family Medicine Department before serving as associate dean of the College of Health from 1968-1973. He also served as interim head of the Department of Family Practice, Community Medicine and Dentistry. He retired in 1985 and was awarded the OU Professor Emeritus. He also received the Don Blair Friend of Medicine Award from the OSMA.

James Thermon McInnis, MD
1910-1999

James Thermon McInnis, MD, died December 18, 1999. Dr. McInnis was born in Carthage, North Carolina on June 15, 1910. Dr. McInnis received his medical degree from the University of Oklahoma School of Medicine in 1937 and was a life member of the Oklahoma State Medical Association.

Douglas Lyons Polk, MD
1949-1999

Douglas Lyons Polk, MD, died on December 19, 1999. Dr. Polk was born on November 17, 1949 in Oklahoma City, OK. He received his medical degree from the University of Oklahoma College of Medicine in 1977 and was a member of the Oklahoma State Medical Association.

Thomas S. Llewellyn, III, MD
1936-1999

Thomas S. Llewellyn, III, MD, died December 26, 1999. Dr. Llewellyn was born in Tulsa, OK, June 13, 1936. He received his medical degree from the University of Oklahoma College of Medicine in 1961 and was a member of the Oklahoma State Medical Association.

John Preston McDaniel, MD
1953-1999

John Preston McDaniel, MD, died December 27, 1999. He was born on April 12, 1953 in Mangum, Oklahoma. Dr. McDaniel received his medical degree from the University of Oklahoma College of Medicine in 1982. Dr. McDaniel was a member of the Oklahoma State Medical Association

Joe Earle Tyler, MD
1917-1999

Joe Earle Tyler, MD, died on December 31, 1999. Dr. Tyler, a life member of the Oklahoma State Medical Association, was born on January 6, 1917 in Chalk, Texas. He received his medical degree from Vanderbilt University School of Medicine in 1942.

Hwan X. Youn, MD
1948-2000

Hwan X. Youn, MD, died January 2, 2000. Dr. Youn was born in Seoul, Korea, on December 22, 1948. He received his medical degree from the Catholic University College of Medicine in Seoul in 1973. He was a member of the Oklahoma State Medical Association.

In Memoriam

1999

Fay Knickerbocker, MD February 6
Charles L. Johnson, Jr., MD February 8
Ramon G. Blanco, MD March 5
Neal A. Pickett, Jr., MD March 14
Henry D. Wolfe, MD March 29
Winfred L. Medcalf, MD April 1
Robert P. Dennis, MD April 6
Emil F. Stratton, MD April 7
Carl W. Smith, Jr., MD April 8
George L. Hill, MD April 20
Jim M. Taylor, MD April 28
T. Jeff Williams, MD May 17
Thomas Ross Ahrend, MD May 23
Lawrence E.C. Joers, MD June 5
Hyman J. Drell, ... July 15
Lee Bailey Word, MD July 22
Dave B. Lhevine, MD July 31
Michael Allan Houghton, MD August 16
Webb M. Thompson, Jr., MD August 20
Perry A. Lambird, MD August 25
Nolen L. Armstrong, MD September 12
George R. Randels, MD October 2
George B. Carter, MD October 7
John Robert DeBiase, MD October 17
Theodore Turnbull, MD October 19
Sol Wilner, MD October 31
Malcolm Horne, MD November 3
William Clark Cheek, MD November 11
Bill B. Elrod, MD November 17
Donald E. Johnson, MD November 18
Allen E. Greer, MD November 19
Beverly Colvin Chatham, MD December 2
Norman A. Cotner, MD December 3
Alan Knight Braly, MD December 9
Wilson David Steen, PhD December 12
James Thermon McInnis, MD December 18
Douglas Lyons Polk, MD December 19
Thomas S. Llewellyn, III, MD December 26
John Preston McDaniel, MD December 27
Joe Earle Tyler, MD December 31

2000

Hwan X. Youn, MD January 2

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All manuscripts should approximate the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual of Style*. An abstract of 150 words or less should accompany each manuscript, stating the exact question considered, the key points of methodology and success of execution, the key findings, and the conclusions directly supported by these findings.

Bylines may contain no more than six (6) names and shall include only those individuals who can attest that they have contributed to the conception and design or analysis and interpretation of data, drafting the article or revising it critically for important intellectual content, and the final approval of the version to be published. Other contributors may be recognized in an acknowledgment.

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The 1999 legislative season was a good one for Oklahoma physicians and patients, and we hope to be able to say the same thing about the 2000 season.

With the tobacco settlement monies on the table for disbursement and with the ongoing efforts of non-medical doctors trying to increase the scope of practice, it will take all of us to make this year a success. Can we count on you?

To help get us off to the best start, the OSMA and the OSMA Alliance are sponsoring Medicine Day at the State Capitol to be held on Wednesday, March 22. This day will give physicians and Alliance members from across the state the opportunity to meet with their Legislators on their own turf (the halls of the legislature) and talk about the issues that are important to medicine and to the health care of the citizens of Oklahoma.

The day will begin at with registration and coffee at 9 a.m., followed by addresses by **Gov. Frank Keating** and other leaders in our state government and legislature. **Dr. Ed Brandt**, chair of the OSMA Council on Legislation will update us on legislative issues we can expect to be addressed during the 2000 legislative session. And finally, lunch will be provided for all attending this Medicine Day session, as well as for your legislators and their staff.

It's not too early to let your legislator know you would like to have lunch with him/her that day. This event will conclude by 1 p.m., or you may want to stay at the Capitol and go to the galleries of the House or Senate and listen to the legislation being made.

For those who may be making their first appearance at the State Capitol, you can also have the opportunity to take the scheduled tours of this historic building or take the time to visit in your legislator's office.

Get out your calendars now and circle March 22 in red to remind you and your office staff of the importance of our being at the State Capitol that day. We are the best-qualified voices our legislators can hear when they are considering legislation with regard to the practice of medicine. It is up to us to make ourselves be heard ...and seen!

Medicine Day gives us the perfect opportunity to start doing just that! We all...physicians and spouses alike...need to be committed to doing all we can to help our lawmakers make the right decisions on behalf of medical issues.

Let Medicine Day at the Capitol on March 22 be part of that commitment. We all have an opportunity to make a difference, and I urge you to not let this opportunity to pass you by. You will soon receive a registration packet with an agenda and additional information about the day. Should you have any questions, call **Kathy Musson** at the OSMA, (405) 843-9571 or (800) 522-9452.

In the words of Franklin D. Roosevelt, "Let us never forget that government is ourselves and not let an alien power over us. The ultimate rulers of our democracy are not a president and senators and congressmen and government officials, but the voters of this country."



Mark your calendars for Medicine Day at the Capitol March 22, 2000

THE LAST WORD

AMA Offering $1,000 Grants

The AMA Council on Scientific Affairs (CSA) announced that it has 40 $1,000 grants for representatives to attend a series of anti-terrorism "town meetings" to discuss issues unique to physicians, such as civic disaster planning, hospital involvement, educational resources, and the role of physicians in surveillance and as first responders. These monies are made available through a generous subsidy offered by the National Medical Veterans Society.

The AMA town meetings, to be held April 3-5 in conjunction with the Department of Defense's "Medic WMD 2000" Conference at the Hyatt Hotel in Crystal City, Virginia, are designed to help determine how state, county and specialty medical societies can best prepare their members to serve their communities in the event of chemical and/or biological terrorism.

The town meetings will help the AMA and Federation to begin to work together to develop such plans and strategies, an issue the AMA House of Delegates strongly supports.These grants will be awarded on a first-come, first-served basis to each participating organization or society. Recipients can use the funds to defray any costs, including conference registration and travel expenses. To reserve your grant, contact Nancy_Nolan@ama-assn.org, 312-464-5046.

OSMA's "Take Care" Campaign Has Successful Debut

The "Take Care" campaign already is making an impact in Central and Western Oklahoma. Scores of calls requesting information about obtaining the Take Care personal information vials were received by the OSMA in the wake of the January debut of the campaign by Oklahoma City local sponsor KWTV-Channel 9.

The Take Care campaign is intended to help save lives by placing important medical information in the form of an EMS file where emergency personnel can easily find it. The EMS file is a large amber vial containing a health questionnaire that lists vital medical information. These containers are available to physicians on a first-come, first serve basis. For more information, contact Brenda Hays, OSMA Communications Director, at 405/843-9571 or 800/522-9452.

Medicine Day March 22, 2000

Mark the calendar for March 22 to be at the State Capitol for Medicine Day. For information, contact Kathy Musson at the OSMA, 405/843-9571 or 800/522-9452.



JOURNAL

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The *Journal* invites the submission of piquant, constructive commentary, interesting case reports and review articles. The *Journal* supports the mission of the Oklahoma State Medical Association — "to promote the best health for the people of Oklahoma in a professional manner by advocating for patients, representing physicians and promoting the art and science of medicine." The *Journal* promotes and improves health education by reviewing, publishing and distributing original scientific articles provided by physicians and researchers who share their knowledge and perspectives on issues of concern to the physicians and medical students in Oklahoma. (See Instructions for Authors on page 81.)

Call for Photos

For those who enjoy photography, the *Journal* encourages the submission color photographs of Oklahoma scenes or native wildlife for consideration as cover photos.

Call for News

In addition, the *Journal* welcomes general news items featuring medical trends which have an effect on the practice of medicine in Oklahoma. Announcements of an Oklahoma physician's role in a national organization or project are also invited.

Submit Materials

Your submission of these types of materials will be much appreciated. The *Journal* team will be eager to assist in the processing of submissions. Address your envelope to:

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The Rewards

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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

MARCH 2000 VOL. 93, NO. 3

EDITORIAL
A Deunified Unification? 87
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE
We're Busy Preparing for the Future 90
BOYD O. WHITLOCK, MD, TULSA

LEADERS IN MEDICINE
Myra A. Peters, MD 93
RICHARD GREEN, OKLAHOMA CITY

SPECIAL
Do Physicians Counsel Smokers to Quit? 103
MELISSA A. MOHON, MD

SCIENTIFIC
Consumer Assessment of Health Plans Survey Results for Oklahoma Managed Care Medicaid, 1997, 1998, and 1999 109
JAMES S. MILLAR, MD; DARENDIA MCCAULEY, PHD; CHERYL HAYS, RRA; TERRY WINSTON, MA; LYNN MITCHELL, MD, MPH

SPECIAL
State of the State's Health: Still on the Decline 118
JAY A. GREGORY, MD, F.A.C.S.

SPECIAL
Thousands Respond to OSMA Take Care Campaign 119

NEWS
OSMA Leaders Emphasize Significance of Health Report at Briefing, 121...Informational Tour Takes Physicians' Campaign for a Healthier Oklahoma to County Medical Societies, 122...AMA Alliance Notes March Health Obeservances, 122...94th Annual Meeting, 123...Uniform Credentialing Applications - Here at Last!, 132...PLICO Seminars, 133

DEPARTMENTS
Deaths, 127...In Memoriam, 128....CME, 129...Classifieds, 130...Alliance, 135...The Last Word, 136

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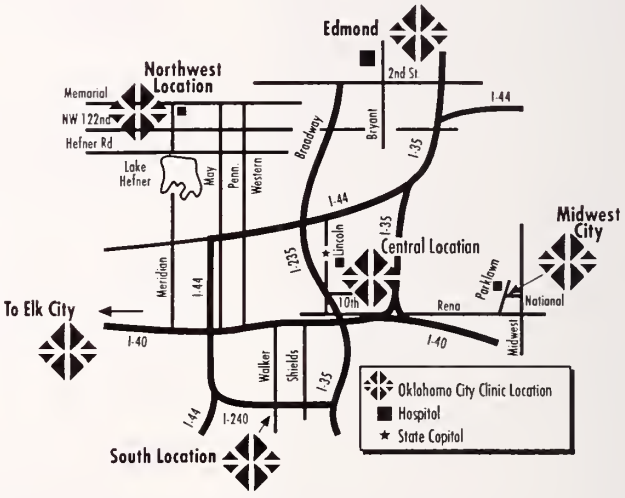
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A Deunified Unification?



I suppose it is time to come out of the closet.

I have now rewritten this editorial three times, not changing my opinion, rather trying to rework the wording to not be offensive. I suppose it is time to add my opinion to the upcoming conflict facing the House of Delegates at the annual meeting of the OSMA. The issue: Unification or Deunification.

For those of you who are unaware of the issue, let me explain the issue, from my perspective. As it currently stands in Oklahoma, we are a unified state. If you are a member of the county medical society, you are a member of the Oklahoma State Medical Association and a member of the American Medical Association.

All three areas of advocacy, a single price and no alternative options.

There is a movement within our state organization to change the rules. Some advocate the "unbundling" of membership. It is not a new movement. I first listened to the discussion at an OSMA annual meeting a decade ago. It has been voted down multiple times by the House of Delegates. There has been continued "behind the scenes" wrangling over the issue. Many of our members, on both sides of the issue, have had this "cause" permeate their lives and political agenda.

I guess I fail to see the wisdom of this move. I fail to see the value of the wasted time and effort that has been spent discussing and advocating deunification. The arguments, as best I understand, are based on the belief by some of our members that it is wrong to require membership in local, state and national societies. There has been growing unrest among OSMA members about the way that the AMA represents physicians, specifically Oklahoma physicians. Our membership is persistently frustrated with the approach taken by the AMA as our national advocacy group. The AMA's bungling of critical issues, their arrogance, or their lack of interest in the individual physician, continues to fuel this frustration. The AMA's difficulties with fiscal responsibilities have raised many eyebrows.

So we are going to take our ball and go home? For this member, it seems a bit shortsighted.

I look at the Oklahoma State Medical Association dues statement on a yearly basis. I divide the dollar amount by 12 to understand what this costs me. I pause at that point to contemplate what I am getting for my money. I make a decision, and I write the check. I have done this for the last 20 years of my career. You might call it a habit. You might call it an unthinking action. You might call it foolish. But I see the action as an excellent investment.

Deunification is going to do nothing to strengthen any of the organizations involved. Will someone explain how this makes OSMA a stronger organization? So the OSMA will have the funding for competent lobbying efforts at the federal level? So national efforts in medicine will be monitored and followed more closely by our membership?

It is true that we all give up a little independence when we link with other groups. But the reality is that we do not have the fiscal means or the membership interest in many of the areas of national lobbying efforts that are currently being managed and tracked by the AMA. Tell me about the efficiency of taking a separatist's perspective on this. It will be extremely inefficient.

I personally find that the deunification arguments miss the mark and are shortsighted. Physicians who want to participate in organized medicine will have done so by this point; it is naive to believe that there are massive numbers

"Deunification is going to do nothing to strengthen any of the organizations involved. Will someone explain how this makes OSMA a stronger organization?"

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

of physicians who will come into the OSMA if the unification requirement is changed.

A representative form of government has ruled the House of Medicine. Why should we abandon that process at this juncture? If the AMA's approach to representing the voice of Oklahoma physicians falls short, that message should be sent loud and clear by our delegation. If you are concerned that the message is not being sent, the problem ends up being our representatives, not the system. If our stance is not a stance that can be supported by our colleagues from around the country, then we had better look more closely at our position.

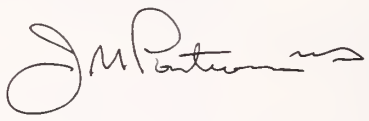
I know it will surprise you, but Oklahoma medicine does not happen in a vacuum. We must remember that we are part of a larger picture.

I appreciate the fact that my membership in Oklahoma is linked. It keeps me from taking the shortsighted approach of only being concerned with local advocacy issues, retiring away from the opportunity to be involved in national issues. There is no way that the voice of Oklahoma physicians can be heard over the din of other advocacy groups. We must learn how to position ourselves within the national organization to assure that our agenda is heard.

If the AMA is to change, it will be from within the organization.

To deunify the OSMA sends the wrong message to the national organization. Let's quit wasting effort on this front and work to make sure that the AMA has a clear focus and provides appropriate advocacy for Oklahoma physicians.

Take a moment to express your opinion to your representative to the OSMA House of Delegates. It is time that they heard from you.



J. Michael Pontious, MD
Editor-in-Chief

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President's Page

We're Busy Preparing for the Future

All physicians know what it means to be a good citizen: to be involved, to get out and vote, and to support good candidates and good legislation with their time and finances. It is just as important to be a good "physician citizen": to support organized medicine in all the same ways. In the last two issues of the Journal I have tried to point out those things that OSMA is doing to make it an association worthy of this support. I will continue this report this month and talk a little about what we need to do in the future.



Our members have asked us to be more aggressive in communicating with the public to improve our image. The Public Relations Council, under the leadership of Dr. Gary Strebel and Brenda Hays, Communications Director, is working with the newspapers and radio and television stations to educate the public about our activities and goals. They are working closely with Dr. Robert Weedn, chair of the Physicians' Campaign for a Healthier Oklahoma, and Joy Leuthard, Director of Health Care Policy and Research, to inform the public and our members about what we are doing to help improve the health of all Oklahomans.

The Building Committee is accumulating data for a report to the membership about the structural changes necessary to improve the acoustics in the Board Room, among other needs, and to determine how best to equip our facility to provide the type of teleconferencing/audio system to best meet our needs. Dr. John Leatherman and the Professional Communications Council are working to improve our Web site and investigating other forms of technology to improve our internal communication. And Dr. Michael Pontious is implementing new ideas and generating renewed interest in the OSMA Journal as its new Editor-in-Chief.

The Member Services Council, under the leadership of Dr. David Nierenberg and Barbara Matthews, Director of Meeting Services and Program Development, is working to update the services offered and to be more responsive to the changing needs of our physicians. PLICO malpractice and health insurance and legal services in areas such as managed care and fraud and abuse continue to be quality benefits for our members.

Integrating the Alliance as an equal partner in all OSMA activities is one of the OSMA's stated goals. In order to accomplish this more effectively, OSMA Associate Executive Director Kathy Musson has been named Executive Director of the Alliance. And with our own Susan Paddack of Ada soon to be inaugurated as the AMAA President, this move is considered very timely.

As we begin a new year, we must give our utmost attention to several areas:

1. We must continue to improve our list of services to our members and our patients. This list includes all those things I have been discussing the past three months.

2. We must work to maintain our membership. With the possibility of deunification, it may become more important than ever that we convince all Oklahoma physicians that they need the OSMA and the AMA. We need to concentrate particularly on the medical students and residents and those young physicians who are just entering practice — those groups that will be the basis for our future. As the late Dr. Perry Lambird stated in an article in our *Journal* back in 1994, "Membership is also power. Everyone who declines to join weakens our power incrementally. Members count, members control organized medicine, and without members, organized medicine is finished. We can increase our OSMA and AMA membership activity and PAC contributions and attempt to serve up an

"We need to look into the future and be willing to make appropriate changes in our association. We need to look not only into next year, but we need to decide where we want to be 5 to 10 years from now."

honorable victory or we can decrease our membership and involvement and accept defeat."

3. We must take an aggressive approach in the area of our finances. We have set up several aggressive programs that we think will benefit physicians and their patients. We have added several new staff to help carry out these programs. We must increase our budget and our income to make Numbers 1 and 2 above possible. We must support a cost-of-living dues increase to give us adequate funds with which to operate.

Finally, we need to look into the future and be willing to make appropriate changes in our association. We need to look not only into next year, but we need to decide where we want to be five to ten years from now. We need to be willing to make changes in our structure, to downsize our board if necessary, to consider utilizing "regional" medical societies (for example).

In the November report of the AMA Commission on Unity (of which Dr. Mary Anne McCaffree is a member), they stated, "A failure to change in a changing environment leads to either the deterioration or the demise of a system because of its failure to adapt to changes." It will take much effort on our part — yours and mine — to create necessary changes. We must all be willing to recognize the need for change in appropriate areas. In the final report of Dr. Jay Gregory's Federation Coordination Team, they discussed several problems that could cause a delay in the progress of organized medicine. One such problem mentioned was "apathy." They said, "Leaders of medical societies have a fixed time commitment, and many are reluctant to address legacy issues on their watch. With so many medical society options, it is easier to just let nature take its course than to consciously drive change."

I hope all of you will continue to support your organization in its attempts to be proactive and to be the kind of organization that will benefit all Oklahoma physicians and their patients.

Sincerely,



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Leaders in Medicine



Myra A. Peters, MD

The Steel Magnolia

Story by Richard Green

Cover by Robert Taylor

Picture a grade school girl growing up during the Great Depression in Sheffield, Alabama. One of nine children born to a railroad engineer and a former school teacher; poor, like nearly all of their neighbors, but not bereft. In order of birth, this girl was lucky number seven, though she never knew two of her siblings. An older brother died during infancy; an older sister was struck and killed by a drunk driver one Sunday morning while she was fetching the newspaper from the front yard for her daddy.

Every so often, some adult would ask this little girl, "Myra, what do you want to be when you grow up?" Twenty guesses wouldn't have been enough. An improbable guess for the time would have been "doctor." And while that was technically correct, it lacked specificity. How people must have guffawed to hear this little girl, small even for her age, declare her answer clearly and unequivocally: "Orthopedic surgeon."

And yet, only a few years later, when she had topped off at five feet two by a hundred pounds, Myra Peters was a medical student at Alabama, then a surgery resident at Oklahoma City's Wesley Hospital and, finally, the first female ever accepted into the orthopedic surgery residency program at the Mayo Clinic.

At age 30, in 1954, Dr. Peters became Tulsa's first female orthopedic surgeon, joining the six men already in solo practice. She wasn't one of the boys and didn't want to be. A southern lady didn't comport herself that way. But she did fit in, operating at both Hillcrest and Saint John's—Tulsa's two major hospitals at the time.

Before the 1950s had expired, her orthopedic colleagues were noticing with some incredulity that this little ol' gal who had come into their bastion was doing most of the operations. She also had developed and headed an orthopedic department at Hillcrest and, with the support of the hospital board, put a stop to the long-standing practice of general surgeons performing orthopedic procedures in the hospital.

By then, the other orthopedists began drifting away to other hospitals. She wasn't glad or sorry to see them go. It was just the natural order of things. The only thing permanent is change.

The cradle of support to a child is a loving, happy, well-adjusted family. Richard and Martha Peters presided over such a family in a town and at a time when civility, politeness, and discipline were more common than they are today. Even the death of two of their nine children seemed to bring the couple and the family closer together. They were such a model family that two cousins, whose own family life wasn't so stable, asked to be taken in. The Peters took them in even though they were barely getting by on Richard's salary as a railroad engineer, and the Great Depression was blanketing the country.

While close to them all, Myra had a particular bond with her father, forged on early morning fishing trips to the Tennessee River. "We'd sit on the bank or in a boat and talk and watch the world come alive," Myra says. She cherished these quiet times with her father because he was often away on train runs, sometimes for three or four days at a time.

Though Richard was a loving parent with a ready sense of humor and a supply of funny stories, he was also strict and had a short fuse. There weren't a lot of rules, but they were rigidly and often corporally enforced, but in reverse of the normal way that infractions were handled by most families. "When we'd do something wrong, Dad would often get mad and yell at us," says Myra, "but it was Mother who did the whipping, with a hickory switch called 'the arm of authority.'"

They grew a lot of their own food, caught fish, and sometimes hunted squirrels and rabbits. (Myra's cousin Bub showed her how to use a .22.) The family's long table and benches served as the gathering place for meals and homework, supervised by Richard and Martha.

Entertainment costs were low. "Many nights, we'd just sit out on the porch, and it was so quiet

in our town that our parents talked with our neighbors who were on their porches," recalls Myra. "I remember once sitting out there in the dark, listening to my mother talk about how much she missed my sister who had been killed by the drunk driver. Mother kept all of her things, her clothes, a toy chest, some China dolls."

Strong faith in God helped Richard and Martha through that tragedy. They read Bible scriptures aloud every day and attended the Church of Christ in Sheffield. In some ways, the church was an extension of the family. Once, when some teenage members had been spotted honky-tonking, the minister lined them up in front of the congregation and had them apologize for their sinful behavior.



Myra did well academically but the smartest thing she did in high school was to work for Dr. Wyatt Heflin Blake, the family's G.P. She had become interested in becoming a doctor a few years before, following a conversation with a neighbor, a nurse named Mrs. Knight, who had asked Myra what she wanted to be when she grew up. Myra smiled and said she wanted to be a nurse just like her.

Nurse Knight's own smile faded, and she said emotionally, almost fiercely: "You will not. You are not going to be taking orders from any doctors; you are going to be giving the orders." Startled, Myra replied with a weak, "Okay." But, as she says, it was the germ of an idea that quickly blossomed. It seemed logical, then, to work for a doctor and better still for the man who took care of the family and had delivered her baby brother.

Blake took on Myra because he recognized that while she was still "a little girl," she had what it took. She got paid $5 a week during school and $20 weekly during the summer. He taught her to use the X-ray and do blood work and urinalyses, how to stop bleeders in surgery, and to deliver babies. She nearly became ill the first time she poked through a bulging membrane and was faced with gushing meconium.

She blanched. Dr. Blake laughed and said, "Get used to it."

Besides learning the technical side of medicine, Myra also observed and absorbed the art of medicine as Blake conversed with his patients. All of this before high school graduation. In many ways, she was already much better prepared for medical school than the great majority of first-year students. And she hadn't attended college yet.

"One day I told my father that it was time to 'get serious' about my attending the University of Alabama. I would need his help financially. He said, 'Okay, let's get serious.' Then he reminded me that he hadn't given any money to my older brothers when they left home. And he said he wouldn't give any to me either. 'But I'm a girl,' I said. 'So what?' he said. In effect, if I wanted to go to college, I would have to pay my own way."

Caught off guard, probably deeply disappointed, Myra regained her equilibrium rather quickly. Okay. She would show her father, she would show everyone. She had been voted "most likely to succeed" by her senior classmates, and right there in the yearbook, in a section of prophecies, it was recorded that Myra Peters would become a famous surgeon. Of course, she had been telling everybody that for years.

There was one piece of unfinished business, however, during her senior year. Myra had been "going steady" with a boy since the sixth grade and at some point it had become understood by both teenagers that following high school graduation they would be married. As graduation approached, Myra held on to both ambitions: marriage and medical school.

Then, one day an older brother disabused her of the notion. His premise was: If you marry that boy, you will never be a doctor. His argument was so persuasive that Myra decided she had to choose. When she told the intended that she wouldn't be marrying him, he took it hard but managed to marry another girl two weeks later! Some decades later, he and his wife and Myra had dinner together in Tulsa. Although they hadn't seen one another in years, Myra told him that he had always been one of her favorite people. He died last year in Tupelo, Mississippi.

Myra never seriously considered marriage again. "In a marriage your first obligation is to your husband and children," she says. "I always thought that a family would have compromised my career too much. Things just evolved in a natural way. I never fell in love again."



Myra Peters, MD, is pictured as a medical student in 1949.

Myra entered the University of Alabama when she was 17 and worked two to three jobs simultaneously to pay expenses and squirrel away money for medical school. She graduated at age 20 with a 3.8 grade point average. "When you have a goal, there is no sense pussyfooting around" is how she explained her march through Tuscaloosa. Interestingly, she had a fall-back plan that was almost as enticing as medicine. For some reason the aesthetics of English literature had appealed to her since high school, and she could see herself teaching the subject in a small college in a nice, quiet town.

Money wasn't a big problem in medical school even though the dean told Myra that she couldn't work during the first two years. She had saved some money, and her tuition and books were picked up by the Colbert County Medical Society. (Each county society in Alabama sponsored one student per year.)

The freshman class at Alabama in 1942 had 60 members, of which a mere 32 graduated four years later. Two were women who dropped out to get married; the other seven women, including Myra, graduated. Most of the failures, by far, were servicemen who had been ordered into medical school. "It was obvious that they lacked dedication," Myra says. One of them, however, turned out to be Myra's study partner and later developed the requisite dedication. They had what they considered to be an uncanny ability to know what would be on the tests. They reprised their knack several years later when they got together the night before part one of the orthopedic surgery boards in St. Louis. "It was just like old times," Myra recalls. "We looked up from the test periodically to look across the room and smile at one another." Incidentally, when she passed the boards, she was the seventh woman to do so.

Asked for a medical school highlight, she tells about a man who was scheduled for surgery the next day. "As the medical student, I performed an exam, asked questions, and consulted my physical diagnosis book. In the patient's chart I recorded a differential diagnosis of leprosy. Now, I'd never before [or since] seen a case of leprosy, Birmingham was not leprosy country, and the attending's diagnosis was something else, I forget what, but certainly not leprosy. Well, the attending called me the next day and said, 'Explain yourself.' I went over the signs and symptoms and said it was all in the book [physical diagnosis]. Turns out I was right."

Though in 1946 she knew little more about orthopedic surgery—including whether she had any talent for it—than she did in 1942, she was determined to land an internship position that would advance her toward her goal. A nurse friend of hers who had previously worked at Wesley Hospital in Oklahoma City recommended she visit that hospital.

It was, Myra found, a mecca of excellent orthopedic surgeons, including Robert Holt, Charlie Roundtree, and famed sports medicine surgeon Don O'Donoghue. When she was accepted there, she was luckier than perhaps she knew. Not only was she with superior surgeons and teachers, but she was not teased, hazed or patronized by anyone connected with the Oklahoma City clinic. "They were kind and polite and never said a cuss word in front of me," she says, adding for effect, "At least not twice."

From internist David Paulus, she learned a great line that she has used as a tension-breaker ever since. As she recalls: "One day this particularly difficult female patient was complaining on and on about this and that and all the while Dr. Paulus was writing away, stopping every so often, to murmur something or say 'hmmm.' Suddenly, he interrupted her stream of complaints and asked if she knew how to spell asparagus. Clearly offended, she said she had not been talking about asparagus. Paulus said, 'I know, but I'm writing my daughter about what we're having for dinner....'"

Years later when Dr. Peters occasionally faced some quandary during surgery, she would look around the table at her team and say: "How do you spell asparagus?"

She learned the real "nuts and bolts" about surgery from Robert Holt and patient communication and compassion from thoracic surgeon Ed Fair. "One day, I saw him delivering bad news to a family. Then, they were all crying together. I had never seen a doctor cry before, but I learned from him that it is okay to cry."

After she completed her internship in 1950, she stayed for an additional year of general surgery and then decided to pursue a goal she had been dreaming about for years: an orthopedic surgery residency at the Mayo Clinic.

Drs. Holt and O'Donoghue wrote letters of recommendation and such was their stature that Myra was granted an interview. She was questioned by the chief, Ralph Ghormley, and then by seven or eight of his staff, one by one. It was a long and exhausting day, but exhilarating. The Mayo orthopedists were all thoroughly professional and polite and Myra thought she had answered their questions, none of which were about orthopedics, in an honest and straightforward way.

Then, she went back to her hotel, fell asleep and next day drove back to Oklahoma City. A few weeks later a letter arrived from Dr. Ghormley saying she was in. She would be Mayo's first female orthopedic resident and one of seven orthopedic residents accepted from applicants around the world.

Although she was awed to be there, she was also confident. "You had to be," she says.



Dr. Peters poses in her new office in Oklahoma City in 1954.

Nostalgia has a way of inflating or magnifying experiences. So it is that when Myra Peters reminiscences about Mayo, she tends to speak in superlatives about the staff and the surgeries. "We got the most difficult cases, everything that was impossible everywhere else. Procedures like hemipelvectomies or similar radical procedures for shoulders. Those things almost got to me. I didn't know how a body could stand all that surgery."

Talking with patients who were facing or who had sustained radical surgeries was part of learning the specialty. Fortunately for Peters, she had always had good communication skills. "You can be taught to an extent, but the ability is inside you or it's not."

In her case, she believes the same was true for the technical side of surgery. "I was always mechanically inclined. I did car repair and maintenance and woodwork just like my brothers. And then I had a knack for orthopedic surgery from the beginning. Learning and understanding and conceptualizing came easy. Not only did I learn a great deal about how and why you do things this way and not that way, but a knowledge of geometry was invaluable. You have to understand angles before you go cutting



Dr. Peters displays a "geometric fascinator" she built.

someone's bones. And you have to be able to see the problem and the result of your work before you start. If you can't visualize the result, you probably should back off."

She met several famous athletes and other well-known personalities who were being treated at Mayo, but the one who had the greatest impact on Peters was a little old lady who grew up in Tuscumbia, Alabama, a neighboring town of Sheffield. Their contact was limited to a brief conversation (through an interpreter) and a handshake, but it was "an absolute joy to meet Helen Keller. Her childhood home was only a few miles from Sheffield, and here we were meeting in Minnesota."

From Mayo, Peters had the opportunity to settle in many choice locations in 1954. One place, believe it or not, had a distinct advantage because she liked the euphonious sound of its name. "I used to tell my parents that I was gonna run away from home. They'd ask, 'Where you going?' I'd always say 'Tulsa, Oklahoma.'"

Actually, she was recruited by a Mayo patient and Tulsa civic leader named John Dunkin. As his guest, she spent a week in the "Oil Capital of the World," as Tulsa used to bill itself, seeing and being seen. Dunkin was so persistent and persuasive that she decided to take a chance. "The orthopedic surgeons in town greeted me cordially," she recalls. "Two of them no longer wanted to take call so I volunteered. I got privileges at Saint John's and Hillcrest and operated every chance I got. I didn't solicit patients but introduced myself at meetings of the Tulsa County Medical Society. She was a new member the old members wouldn't likely forget. There were very few female members, probably no female surgeons, and definitely no female orthopedic surgeons!

Peters brought two nurses with her. One was scrub nurse Marie Brunner, who had been a head orthopedic nurse at Mayo. The other was Myra's sister Eugenia whom everyone called Boots. She was her sister's office nurse and manager. The three not only worked together, they lived together in Myra's house, which she expanded incrementally over the years. Boots retired in the early 1970s and moved across the street. Marie still lives with Myra in the house, which is now quite spacious for two people.

Peters says she never had any problems with the male physicians. That may have been so when she was busy building her practice. But by the early 1960s, observers noted that she was dominating the field in Tulsa and that relations with her colleagues were not always smooth. Two physicians who were in a position to know, internist Craig Jones and anesthesiologist Duane Brothers, worked with her at Hillcrest for more than 30 years. "From the start, several physicians were watching for her to make a mistake," Jones says. "Certainly she had to fight to prove her ability."

Jones says that she also was establishing an orthopedic surgery department and standards of care that threatened some doctors. "On levels of animosity from one to ten, there were some tens who accused her of trying to take away their livelihood. There were strong words exchanged and some battles, but Dr. Peters was forceful, reasonable, coherent, and decisive in defending her position. And she had the backing of Hillcrest administrator Jim Harvey, who had been hired to preside over the improvement of the hospital's clinical services.

Brothers, whose group provided the anesthesiology services for the hospital, says flatly that she was the best surgeon he had ever seen. "Technically, Myra was almost flawless, a fast but supremely beautiful technician. She knew how to manipulate arms and legs, including shoulder and hip displacements, without having

to exert a lot of physical effort herself. I don't think she ever needed any help." Actually she did once. When called upon by her, a male colleague used his superior strength to set a child's forearm fracture, but the X-rays showed that somehow he'd gotten the bones reversed, the radius was on the ulna and vice versa. "Thank you very much, sir," said Myra, who was then able to set the fracture herself. "I teased him about that for years," she says.

According to Brothers, Peters got along well with the other members of the surgical team, but she didn't like dawdling. "She'd note the time just before starting the operation and at the end; I'm sure she took pride in working quickly. If things didn't go the way she wanted, she would correct people, sometimes a bit harshly, but she never threw tantrums or instruments, and after she'd had her say, the matter was over. She didn't pout or stay irritated."

By the time Brothers arrived in 1959, most Hillcrest-affiliated physicians were referring their orthopedic cases to her. She had such volume that she was scheduling surgeries way ahead of time, picking the prime early morning surgical slots. Unfavorable comparisons (with Peters) and inconvenient scheduling, Brothers says, may have caused some orthopedists to decide to move to other hospitals.

Another possibility that Brothers didn't mention is that some men couldn't abide being eclipsed by a woman. In the other surgical specialties, no exodus of less talented surgeons occurred. When she says she had no trouble with her male colleagues, she may have meant that they were no real threat. At any rate, she overcame obstacles and opponents not with arguments, manipulation or power plays, but by continuing to be a superlative surgeon who was obviously dedicating her time and talent to her patients and the hospital.

She was elected president of the Hillcrest medical and dental staff and in 1968 she was elected the first female president of the Tulsa County Medical Society. Several years later, she was one of a few Hillcrest physicians whose service to the hospital was rewarded with two airline tickets to anyplace in the world.

By that time, she had stopped flying her own airplane. She had begun sometime in the early 1960s after being encouraged by two or three flying doctors. Actually, her yen to fly started when she was about 5 years old. One day, Myra and her playmates were surprised to see an airplane flying overhead. To their added amazement, it landed in a field nearby. When the pilot took off the cap and goggles, they saw it was a woman. And she introduced herself to the little girls. Her name was Amelia Earhart.



A former pilot, Dr. Peters rescued this wooden propeller from being burned.

Many years later, at the urging of some colleagues, Peters took flying lessons and then purchased a Cessena Skylane 182, a four-seater that had been wrecked but thoroughly rehabilitated. She enjoyed flying, and most of her trips were back home to Alabama to visit her parents. "With a tailwind, the trip from Tulsa to Muscle Shoals took a little more than two hours," she says. Weather can be a problem, but Peters was always careful. If the forecast wasn't favorable, she wouldn't fly.

One time, however, she had been visiting her family in Alabama and had to be back in Tulsa for a scheduled surgery. Before she got to Memphis, it was raining and hailing. She made an unscheduled stop there in the driving rain. When the weather cleared, she filed a flight plan and took off. Near Conway, Arkansas, terrifying storm clouds materialized out of nowhere. Very quickly, the ceiling dropped down around her. "I did a quick 180 and put her down in a field just as fast as I could."

She landed okay, but before she had taxied to a stop, a wheel sank down into a hole. A couple



Dr. Peters takes special pride in her home, which includes an indoor spa.



Well-wishers showered Dr. Peters with gifts upon her retirement in 1990.

gave her a ride into town, where she made calls to Tulsa, including one to her flight instructor, who said he needed to come examine the plane. She returned to the plane to wait. About noon, the couple returned leading a veritable caravan of pickups. "All of these mountaineers emerged bearing a tremendous supply of food — fried chicken and all the fixin's," Myra recalls. (Just for the record, there are no mountains near Conway, which is just north of Little Rock.)

After the group ate lunch, they were surprised to learn that this little lady was a "cutting doctor." Soon, Myra's flight instructor arrived, pronounced the plane flyable and helped "the mountaineers" pull the plane out of the hole. When he suggested that Myra fly the plane back to Tulsa, "I told him I didn't want to, and that I would ride with him. But he said, 'We can't just leave it here. You have to fly it back.' I held things together until I gained altitude, and then I started shaking, and then crying uncontrollably. By the time I landed in Tulsa, I knew my flying career was history."

A Hillcrest colleague told Myra a few weeks later that he had heard from one of the witnesses to the episode. The man said, "Doc, hasn't been a hen lay an egg since."

Since the late 1950s, Peters had been performing three to five operations a day, ranging from 11 minutes to remove torn cartilage from a knee skin to skin ("Why don't you go faster, Myra?" her colleagues teased.) to about two hours for a total hip replacement. She started doing total knees after her own knee had been replaced by Oklahoma City orthopedic surgeon Steve Tkach in 1974. To prepare, she attended a course in the procedure and reviewed the slides of her own knee provided by Dr. Tkach. In the 1970s, she was occasionally inundated with patients. And while she never helped lessen her load by recruiting orthopedists, she did welcome those who were qualified. She also notes that "inundated" isn't the same as "overwhelmed." Still, there were times when she had to admit that she was very happy when vacation time arrived.

Her most memorable vacation was to Maui in 1981. "The red flags were out on the beach, meaning stay away from the water. I was walking on the beach where the surf would occasionally lap up onto my feet. At one point, I had my back to the ocean and suddenly a huge wave crashed into me at a speed estimated to be 75 miles per hour! Wham-O! I went up in the air, upside down and saw my left leg going round and round, clearly broken. I reached up and grabbed my femur hard as the wave spit me out onto the beach. I still had hold of the femur, which looked like it was about to pop through the skin on the lateral side near the knee. I thought, Oh my God, I've got to reduce [set] that sucker. With all my might, I set the bone and didn't feel a thing."

Meanwhile, Myra's companions, having just emerged from the hotel to see their friend in such dire straits, were all screaming and crying. While they waited for the ambulance, Myra noticed that her left leg "was a little short," and asked Marie, her friend and scrub nurse, to grab the leg and pull it down to hold traction. "This girl came along as I was getting a little shocky and told me to ask for Dr. So-and-So when I get to the hospital. So I did. Fortunately, this doctor was a well-qualified orthopedist. When he asked me why I'd asked for him, I told him about the girl on the beach and said, 'You have a funny way of advertising here.'"



A miniature train display is just one of many projects Dr. Peters has undertaken.

Over the years, she was content to live and work in Tulsa. A few academic institutions made overtures, which she politely declined. She did ask her old Mayo mentor, Dr. Ghormley, about one attractive offer, but he advised her not to take it. "You wouldn't be happy there. You are a doer." In the 1980s, after practicing for 30 years, Peters took on an additional assignment. Although very different from orthopedic surgery, it is its natural extension. She was named medical director of Hillcrest's Tulsa Rehabilitation Center (TRC).

It was supposed to be a full-time job, but since Peters didn't want to give up her practice, she was allowed to cram both jobs into 24 hours. She'd show up at the 50-bed TRC at 5:30 a.m. to make rounds, often waking up the patients in the raucous way her brothers used to wake her up. After rounds, she would drive back to Hillcrest to complete her surgical schedule, then U-turn back to TRC. She kept it up for five and a half years and felt she got more from TRC than she gave.

One of the reasons she did well was because she never confused the goals of orthopedic surgery with those of rehabilitation medicine. In working with people who are severely disabled by strokes, head injuries, and spinal-cord injuries, she says the main goals are to regain lost function to the extent possible and to learn to live with the residual disabilities. This involves problem-solving, and while Peters was no stranger to that, some of the problem-solving in rehab has to be done by the patient. Her job, in part, was to encourage and to motivate, and she believes she was effective even when she felt like her heart was breaking. The young ones gave her the biggest problem emotionally. "I love children, and it was painful to see them lashing out at the world that had dealt them such a cruel blow. Sometimes I felt like I had their lives in my hands."

Now, in her 76th year, Myra Peters has no regrets that she had no children of her own. She made her decision at the end of her senior year, and she was never tempted to change it. She was married to her profession, and for an ambitious



Whether designing a sunroom,



restoring a beautiful piece of furniture, or performing delicate surgery, Dr. Peters' hands have always been engaged in creating, healing, and making the world a better place.

female surgeon competing in the man's world in Tulsa in the 1950s, it wouldn't take too much imagination to see that that was probably necessary.

It didn't mean, however, that she had no children around her. Peters taught Sunday school for more than 40 years. And after she began her practice, she started financing the education of her nieces and nephews. Now she is financing another generation of relatives, and several years ago she branched out to pay tuition and provide spending money for some children at her church.

Though she was never interested in the business of medicine and calls doctors who enter the profession to get rich "sinful," she has proven to be a successful investor in the stock market. The best advice she ever got was in a short course on stocks and bonds. In essence, it was: don't buy and sell, buy and hold on.

Peters retired in 1990. "I thought about it for a few months because I still enjoyed doing the surgeries, and I don't believe I had lost much if anything. But I had to admit that I was almost always tired physically. Then, this feeling came over me that this was the time. Some patients tried to talk me out of it. You know, 'What will I do?' I said, Go to another orthopedist; there's plenty around."

"That's Myra," says Duane Brothers, "clear and decisive. You never have to ask twice." Dr. Brothers keeps a framed poem in his living room that was written and delivered by Myra Peters on the night she handed over the gavel to her successor as president of the county medical society. She titled it "Progress."

I'd rather be a could-be if I couldn't be an are.
For a could-be is a maybe with a chance of touching par.
And I'd rather be a has-been than a might-have-been,
For a might-have-been has never been
But a has-been once was are.

Do Physicians Counsel Smokers to Quit?

Melissa A. Mohon, MD

Introduction

Smoking is arguably the largest public health concern in the United States. More than 400,000 Americans die annually of illnesses directly related to smoking. Over $80 billion is spent each year on health care for smokers.[1] Unfortunately, the number of smokers in the United States has remained constant, despite extensive anti-smoking campaigns. For each smoker who quits, another takes up the habit. Every day approximately 3,000-6000 children and teenagers take their first puff on a cigarette, many of them continuing on as lifelong smokers. A recent study in Indiana showed the prevalence of cigarette use by students in the fifth grade at 13.9%, sixth grade 20.9% and seventh grade 31.7%.[2] In Oklahoma, the prevalence of smoking increases from 31% in ninth graders to 38% in twelfth graders.[3]

The tobacco industry spends in excess of $5 billion for marketing and advertising each year, historically targeting the above age groups.[1] New legislation and litigation has purportedly led to the elimination of children and teenagers as a target market; however the total advertising efforts have not changed, and many feel that the ads still target teenagers, perhaps in more subtle ways. In contrast to the multiple billions of dollars spent by the tobacco industry, the total national budget for smoking cessation intervention is less than $1 billion.[1]

There have been various efforts to impart smoking cessation intervention skills to physicians, among them the promulgation of the U.S. Department of Health and Human Services (DHHS) Practice Guidelines, the National Cancer Institute Smoking Cessation Program, and the American Heart Association Program. In 1996, the Robert Wood Johnson Foundation provided the American Medical Association $10 million to send pocket copies of the U.S. DHHS Guidelines on Smoking Cessation to 200,000 primary care physicians.[1] Despite the vast array of guidelines and cessation information widely available to physicians, the percentage of smokers in the United States remains constant, which leads one to the question: Are physicians taking an active role in advising their patients to stop smoking?

Evidence

Despite the fact that smoking is the single greatest modifiable cause of disease and death in the United States, only half of all smokers surveyed report ever having been urged to quit by their doctor.[4] Forty-eight million Americans are smokers, 25% of the population. Seventy percent of the population contact a physician each year and most average four visits a year.[4] Even if only half of the smokers in the United States see a physician twice a year, there would be almost 50 million opportunities for smoking cessation intervention, ample opportunity to make some kind of progress.

Despite the fact that only about half of patients report ever being counseled to quit, 75%-90% of primary care physicians report that they provide smoking cessation counseling to all or most of their smoking patients.[4] There is likely to be some bias on both sides of this issue. Many patients who are not interested in quitting may not recall that their physician discussed this issue and are more concerned with their health problems. Physicians may over-report the number of interventions either because they don't want to admit that they occasionally forget such an important issue or because they sincerely think that they do talk

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about smoking cessation with their patients. The actual percentage of interventions is probably somewhere between these two figures, with approximately 55%-70% of patients being counseled to quit smoking.

It has been well established that when smoking cessation counseling is done, physicians can and do have a significant effect on the smoking behavior of their patients. The Agency for Health Care Policy and Research (AHCPR) claims that simple advice is better than no advice at all and that the success of intervention increases with the number of modalities and the number of times smoking cessation is mentioned.[5]

Smokers were more likely to report being advised to quit if they were older, were seen in a private physician's office (as opposed to an HMO or an emergency room setting), if they rated their health status as fair to poor, if they smoked more than 20 cigarettes a day, or if they were thinking about quitting. Women were more likely than men to have received counseling, as were the employed versus the unemployed. Those patients with a higher level of education were more likely to have received counseling and to have been prescribed medication, such as the nicotine patch.[4]

Discussion

These statistics reflect several things. Older people are more likely to have been long-term smokers and are more likely to be in poor health, both from smoking and for other age-related reasons. Therefore while they are very likely to have been advised to quit smoking, they are also more likely to recall being advised to quit because they are considering quitting as a way of improving their health status. Unfortunately for most of these people, this advice is too little, and the tactic too late. Patients who are seen in private offices are more likely to have a long-standing relationship with a particular physician than those seen by a doctor who works for an HMO and are therefore more likely to be counseled. This is a disturbing trend as the number of solo, or private, practices is dwindling in the United States today. Women see doctors more than men, so there are more opportunities for them to be counseled. People who are employed are more likely to be counseled because they may belong to a health plan at work or can afford a higher number of visits than those who are unemployed and have no insurance or do not belong to a health plan. Patients with a higher education level are more likely to be prescribed medication because their physician believes they will be compliant with the medication instructions.

A significant proportion of new smokers are adolescents. From the data, it is apparent that this subset of patients is vastly undercounseled. They are young and usually in good health and generally smoke fewer cigarettes a day. Adolescents represent a group that physicians should be targeting, as intervening with this group will have the greatest long-term impact. Older smokers are likely to have already incurred significant health care costs to the system due to their smoking behavior and subsequent health-related impact. Regardless of whether they quit smoking or not, the health consequences of long-term cigarette use is evident in that disease has already been initiated.

This is not to say that a smoking cessation strategy should not be instituted in the older smoker, as it will markedly decrease the amount of second-hand damage that their smoking will potentially do to others. However, smoking cessation will not likely reduce total health care costs for older smokers to the degree that is expected when counseling younger smokers. Younger smokers have not yet cost the health care system a significant amount. If physicians can be successful in targeting this group with smoking cessation interventions, a substantial health care cost burden can be avoided in the future.

If physicians understand the benefits of counseling patients and understand the additional benefit of counseling adolescents in smoking cessation, why doesn't cessation counseling occur more often?

Barriers to providing smoking cessation counseling that have been cited in the literature include limited reimbursement for smoking cessation counseling from insurance providers or third party payers, limited time from the physician who is under pressure to be more "cost-effective and efficient," and limited resources and skill of office staff to assist with smoking cessation efforts.[2,4]

Concerns about reimbursement are often generalized by the clinician, burdened by greater and greater "requirements," with no compensation for the effort. Smoking cessation intervention is often seen as an additional clinical burden. To ask the question "Have you ever thought about stopping smoking?" does not take much time or effort. The time involved is limited to patients who give an affirmative answer. Follow-up visit reimbursement for those that are quitting may create reimbursement difficulties, if

that is the sole reason for the visit. As for resources available to physicians and their staff, the difficulty is one of efficiently finding those resources and applying them to the clinical setting. Although it only takes a few minutes to give a patient a pamphlet that will perhaps stimulate discussion on a subsequent visit, the clinical system must be prepared and focused on taking advantage of this "intervention" opportunity.

While these barriers definitely play a role in the lack of provision of consistent smoking cessation advice, they may represent two much larger problems. The first is the lack of physician confidence in counseling smokers, either due to their lack of experience in appropriate methods or due to their perception of lack of success in getting patients to quit, despite what seems to be adequate advice.[2] Smoking cessation intervention methods are rarely taught in medical school, despite multiple citations in the literature suggesting the benefit of adding cessation training to the medical school curriculum.[2,5]

The availability of clinical guidelines is not necessarily associated with the appropriate implementation of those guidelines. In a study of Indiana family physicians who had been trained in smoking cessation guidelines, 48.2% felt that their counseling efforts were not effective.[2] The guidelines available are not viewed by the clinician as being consistently useful in getting patients to quit. A guideline may tell one what to say but not how to say it in an effective or efficient manner.

Another major barrier in smoking cessation intervention is that physicians often engage in stereotyping,[6] whether consciously or not. The physician may make the decision about smoking cessation counseling based not on their knowledge of the benefits of counseling, but rather by their impression of the patient and their expectation of how the patient will respond to counseling efforts. Using the example of a teenager, two stereotypes are common that impede a physician from intervening or offering smoking cessation counseling.

The first stereotype is that of the "innocent child." The physician believes that an 11-year-old could not possibly be engaged in a behavior like smoking. Because of this belief, the physician chooses to say nothing. The additional confounder that is often present is the presence of the parent in the examination room, restricting the child's answer, even if the question is asked. The second adolescent stereotype is that of the "rebellious" teen who is very stubborn and non-communicative. The physician's prejudice is that this patient would not listen to the doctor's advice, therefore any intervention represents wasted time. Adolescents are historically one of the most difficult types of patient for most clinicians, yet this represents a group in which physicians can have greatest impact. It is extremely important that all physicians be trained in how to deal with adolescent patients.

Additional physician prejudice has been noted with smoking intervention with older patients. Persistent physician interest in smoking cessation for the chronic smoker continues to be a powerful tool and should be considered during each clinical contact with this type of patient.

Recommendations

Reimbursement issues continue to be a concern for smoking cessation services. Fortunately, with the increase in managed care organizations, preventive services have become more reimbursable; however, there is still a trend for insurance companies to be willing to pay for end-result therapies such as treatment for lung cancer or myocardial infarction but not willing to pay to prevent these types of outcomes.[1] Many insurance companies are willing to pay for limited amounts of smoking cessation medications but limit coverage for longer counseling and behavior modification programs. In the long run, preventive services would be much less expensive for the insurance company. Changes need to be considered in the policies of health care organizations and insurance companies, such that these types of services become viewed as cost effective.

In order to make smoking cessation an integral part of the clinic visit, the question of smoking status should be added as a "routine" vital sign.[1,5] Every physician looks at the vital signs at least once during the course of a patient's visit, so this could serve as a "cue" to ask the patient about tobacco use. This tactic will not work with every patient but will certainly cause an increase in the number of interventions that take place in the clinical setting.

The barrier of limited resources and involvement of office staff will likely be more difficult to change; however, it should be done by changing institutional policies. Smoking cessation should be viewed as a priority, and mission and vision statements should be changed to reflect the goals of smoking cessation. Smoking cessation programs can be developed, literature can be provided on smoking cessation, and vidotapes can be run in waiting rooms. In addition, many

useful resources are available free of charge through the American Heart Association or other specialty organizations such as the the American Academy of Family Physicians and the American Academy of Pediatrics.

Consideration should be given to providing high quality continuing medical education courses on smoking cessation for primary care clinicians. The more exposure physicians have to the subject of smoking cessation, the more confident they will be in approaching patients about this behavior modification and the more often they will intervene with patients.[7]

Although effective approaches to nicotine addiction are available, physicians are continuing to have difficulties counseling patients on smoking cessation. There are many methods that can be utilized to increase the number of smoking cessation interventions performed by physicians. The barriers cited can be overcome by increased attention to the problem of smoking cessation counseling and by making it more a part of everyday, routine clinical behavior. Strongly targeting teenagers with effective smoking cessation interventions will have a greater impact on health care costs in the future. This impact will not be seen immediately, this type of intervention must be part of a long term public health approach. Unfortunately, these tactics alone will not be enough to completely eradicate cigarette smoking behavior. Changes in governmental policy regarding the tobacco industry are urgently needed to make any lasting impact on smoking behavior. If the tobacco industry is allowed to continue to produce and advertise their product, physicians will be fighting a losing battle.

The Author

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What Youth Should Know About Tobacco

Tobacco use hurts your health and costs you in many other ways. Here are some facts about tobacco use that every kid should know:

Tobacco and Athletic Performance

- **Don't get trapped. Nicotine in cigarettes, cigars, and spit tobacco is addictive.**
- **Nicotine narrows your blood vessels and puts added strain on your heart.**
- **Smoking can wreck lungs and reduce oxygen available for muscles used during sports.**
- **Smokers suffer shortness of breath (gasp!) almost 3 times more often than nonsmokers.**
- **Smokers run slower and can't run as far, affecting overall athletic performance.**
- **Cigars and spit tobacco are NOT safe alternatives.**

Tobacco and Personal Appearance

- **Yuck! Tobacco smoke can make hair and clothes stink.**
- **Tobacco stains teeth and causes bad breath.**
- **Short-term use of spit tobacco can cause cracked lips, white spots, sores, and bleeding in the mouth.**
- **Surgery to remove oral cancers caused by tobacco use can lead to serious changes in the face. Sean Marcee, a high school star athlete who used spit tobacco, died of oral cancer when he was 19 years old.**

The Bottom Line

- **Know the truth. Despite all the tobacco use on TV and in movies, music videos, billboards and magazines—most teens, adults, and athletes DON'T use tobacco.**
- **Make friends, develop athletic skills, control weight, be independent, be cool..... play sports.**
- **Don't waste (burn) money on tobacco. Spend it on CD's, clothes, computer games, and movies.**
- **Get involved: make your team, school, and home tobacco-free; teach others; join community efforts to prevent tobacco use.**

On Behalf of the Oklahoma State Medical Association's Physicians' Campaign for a Healthier Oklahoma and your physician

We Wish You Well!

Source: Centers for Disease Control's Tobacco Information and Prevention Source. Additional information is available at www.cdc.gov/tobacco.

Patient Handout #3

Parents: Help Keep Your Kids Tobacco-Free

Know the Facts About Youth and Tobacco Use

Kids who use tobacco may:

◆ Cough and have asthma attacks more often and develop respiratory problems leading to more sick days, more doctor bills, and poorer athletic performance.

◆ Be more likely to use alcohol and other drugs such as cocaine and marijuana.

◆ Become addicted to tobacco and find it extremely hard to quit.

◆ Spit tobacco and cigars are not safe alternatives to cigarettes; low-tar and additive-free cigarettes are not safe either.

◆ Tobacco use is the single most preventable cause of death in the United States causing heart disease, cancers, and strokes.

Take a Stand at Home—Early and Often

◆ Despite the impact of movies, music, and TV, parents can be the GREATEST INFLUENCE in their kids' lives.

◆ Talk directly to children about the risks of tobacco use; if friends or relatives died from tobacco-related illnesses, let your kids know.

◆ If you use tobacco, you can still make a difference. Your best move, of course, is to try to quit. Meanwhile, don't use tobacco in your children's presence, don't offer it to them, and don't leave it where they can easily get it.

◆ Start the dialog about tobacco use at age 5 or 6 and continue through their high school years. Many kids start using tobacco by age 11, and many are addicted by age 14.

◆ Know if your kids' friends use tobacco. Talk about ways to refuse tobacco.

◆ Discuss with kids the false glamorization of tobacco on billboards, and other media, such as movies, TV, and magazines.

Make a Difference in Your Community

◆ Vote with your pocketbook. Support businesses that don't sell tobacco to kids. Frequent restaurants and other places that are tobacco-free.

◆ Be sure your schools and all school events (i.e. parties, sporting events, etc.) are tobacco-free.

◆ Partner with your local tobacco prevention programs. Call your local health department or your cancer, heart, or lung association to learn how you can get involved.

Source: Centers for Disease Control's Tobacco Information and Prevention Source. Additional information is available at www.cdc.gov/tobacco.

Patient Handout #3

Consumer Assessment of Health Plans Survey (CAHPS®) Results for Oklahoma Managed Care Medicaid, 1997, 1998, and 1999

James S. Millar, MD; Darendia McCauley, PhD; Cheryl Hays, RRA; Terry Winston, MA; Lynn Mitchell, MD, MPH

Consumer satisfaction surveys have become an important source of information for purchasers and consumers of health care and health care organizations themselves. Individuals receiving health care provide valuable information regarding access, use of services, and satisfaction with care that can be used for multiple evaluative purposes.

The Oklahoma Health Care Authority has adopted the Consumer Assessment of Health Plans Survey (CAHPS®) to measure patient satisfaction for the SoonerCare managed care programs. The Oklahoma Foundation for Medical Quality administered the surveys. The adult and child CAHPS® core questionnaires served as the basis for the general surveys in 1997 and 1998. The CAHPS® for Children with Special Needs survey results and the Pediatric Adaptation of the CAHPS® Behavioral Health Survey results were administered in 1999 for baseline measures.

Results indicated an overall increase in consumer satisfaction levels across the two CAHPS® core questionnaires. Baseline measures for special needs populations were also established.

Introduction

Consumer satisfaction surveys have become an important source of information for purchasers and consumers of health care and health plans themselves. Individuals who are currently receiving health care provide valuable information regarding access to care, use of health services, and satisfaction with the care received. This information may be used to assist both consumers and purchasers of health care to choose health plans. This information serves also to identify areas of improvement for plans.

The Oklahoma Health Care Authority (OHCA) adopted the Consumer Assessment of Health Plans Survey 1.0 (CAHPS® 1.0) in 1997 to measure patient satisfaction for the SoonerCare Plus Medicaid managed care programs. SoonerCare Plus is a fully capitated health maintenance organization (HMO) program serving the Aid to Families with Dependent Children (AFDC)/Temporary Assistance to Needy Families (TANF) Medicaid population in and around Oklahoma's three largest metropolitan areas.

CAHPS® was sponsored by the Agency for Health Care Policy Research (AHCPR) and developed by the CAHPS® Consortium: Harvard University, the RAND Corporation, and Research Triangle Institute. OHCA adopted CAHPS® 2.0 for the 1998 survey. OHCA contracted with the Oklahoma Foundation for Medical Quality (OFMQ) to conduct both general surveys.

The survey results are representative of Medicaid recipients who were enrolled in a specific HMO in the SoonerCare Plus program for a minimum of six months and responded to the survey. This report includes information on the CAHPS®[1,2] methodology, analysis, and summary information on the selected questions as a measure of the patient satisfaction with the SoonerCare Plus program. Where possible, direct comparison of findings between the two years is also presented.

In 1999, due to the success with the general CAHPS® results, OHCA adopted the CAHPS® Children with Special Needs Survey. OHCA also worked with OFMQ to develop the Pediatric Adaptation of the CAHPS® Behavioral

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Health Survey (PACBHS). The adoption was done to measure client satisfaction of Oklahoma Medicaid recipients in the population of children with special needs and in the population of children identified as having received outpatient behavioral health services. The methodology and SAS® analysis used by OFMQ are consistent with the methodology and SAS® analysis established by the CAHPS® Consortium. This report contains the baseline data for both 1999 surveys.

Methods

Sampling

Sampling consisted of randomly selected SoonerCare Plus members for each HMO for each of the adult or child population. CAHPS® methodology set the completed, usable response rate minimum for each plan at 300 for 1997. Estimating a survey return rate of 30%, the 1997 mailed sample was 1,000 per plan for each of the pediatric and the adult population.

To reduce the burden on the respondents, only one survey was mailed to a household, according to CAHPS® recommendation. One plan in 1997 did not have a sufficient number of enrollees to meet the criteria of 1,000 adults and 1,000 children, so the survey was sent to the eligible population. For 1998, OFMQ elected a sample size of 750. One plan had 697 adults selected, using the entire population in place of a sample. Some households in this plan received an adult survey and a survey for one child in the household.

The Children with Special Needs CAHPS® core questionnaire served as the basis for the survey of this group. The CAHPS® Adult Behavioral Health Survey was adapted to use as the base for the child behavioral health study. The questions were modified to enable the parent or guardian of the child to complete the survey for the child. The behavioral health survey is still under development by Harvard but is not yet a CAHPS® survey. Therefore, the modification previously discussed was adopted. The CAHPS® survey methodology allows for contacting respondents by mail, by phone, or a mixture of both. A mail format, with telephone follow-up, was used for both general survey populations.

For the sample from Medicaid enrollees for the Children with Special Needs, enrollee information was provided to OFMQ by OHCA. To reduce the burden on the respondents, only one survey was mailed to a household, according to CAHPS® recommendation. The sample size of 750 was selected from members who met the following criteria:

- The child was enrolled in Medicaid
- The child was eligible for Medicaid as a disability case
- The child was enrolled in a traditional Fee For Service program
- The child was age 18 or under.

For the sample from Medicaid enrollees for the PACBHS, enrollee information was based on Medicaid recipients for whom claims on behavioral health had been paid and was provided to OFMQ by OHCA. To reduce the burden on the respondents, only one survey was mailed to a household, according to CAHPS® recommendation. The sample size of 750 was selected from members who met the following criteria:

- The child was enrolled in Medicaid
- The child was age 18 or under
- The child received outpatient behavioral health services.

Quality Indicators

The indicators had three types of question formats in each year and survey. The answers for 1997 either were dichotomous (yes/no), overall ratings scale (zero to 10), or ranked (always to never). The ranked questions were grouped together for composite ratings on specific areas of health care. For the 1998 and 1999 surveys, the dichotomous response format was replaced with a ranked format of no problem/small problem/big problem, and were included in composite items. The overall ratings scale and the ranked scale in composite format form from the 1997 survey were unchanged in 1998 and 1999. Additionally, the PACBHS had one question with maybe, yes, or no as the response options.

The three overall rating scale questions were used unchanged for both years for the general CAHPS®. The dichotomous question from 1997 on availability of a personal doctor was included in a "problem" ranking question in 1998. One composite of ranked questions had identical questions and format for both years.

Interventions

The intervention for each year of the CAHPS® general survey was the publication of respondent rates for each of the HMOs, listing all the HMOs by name. The report included the associated percent yes for the 1997 survey, average score on the zero to 10 point scale and the percentages for ranked scale for both years. In this way a plan could evaluate its own performance during the prior year and with other plans. A report card identifying composite ratings of sev-

eral questions was disseminated to Medicaid recipients during open enrollment in 1998. The report card provided additional information to Medicaid recipients in choosing an HMO. This same process was followed with 1998 survey data, which was released in the spring of 1999. This allowed plans to compare their performance internally against the previous year as well as among the other plans.

For both the Children with Special Needs Survey and the Pediatric Adaptation of the Adult Behavioral Health Survey, the results are serving as the baseline measure. This is to establish opportunities to improve care and as a benchmark as the anticipated improvement occurs. Interventions will be undertaken after assessment of the results of the survey and evaluation of the resources needed and available for improvement.

Baseline and Remeasurement Procedures

The adult and child CAHPS® core questionnaires served as the basis for the general surveys. For the adults, supplemental modules in 1997 were added about dental care, mental health, pregnancy care, prescription medicine, and transportation. In 1998, the adult supplemental modules were about mental health, pregnancy care, prescription medicine, and transportation. For the children, supplemental modules were added relating to dental care, prescription medicine, and transportation for both 1997 and 1998. In 1998, two other supplemental modules were added to the child CAHPS® survey, one on coverage by multiple plans and the other module with questions covering aspects of the HealthPlan Employer Data Information Set.

The CAHPS® survey methodology allows for contacting respondents by mail, by phone, or a mixture of both. To maximize the response rate, the mixed method was used for both years for the general survey. In addition, in 1998 Federal Express delivered follow-up questionnaires, which were sent after phone prompts. The mail format, with follow-up, was used in 1999 for both the children with special needs and behavioral health survey populations.

Statistical Analysis

The initial analysis of the data was done using SAS® (Version 6.12, SAS Institute, Cary, North Carolina) based software developed by the CAHPS® Consortium. Responses to the questions in the CAHPS® questionnaire were grouped in three categories: overall ratings, single items, and composites. The single item questions in 1997 had yes/no responses. In 1998 and 1999, the single item questions had no problem/small problem/big problem response options. The overall ratings had a response format of zero (worst) to 10 (best). A composite item consists of two or more questions with the same response format that measure similar dimensions of health care. When comparisons between the 1997 and 1998 results were possible and the questions were the same, the Wilcoxon Scores of Rank Sums was calculated, using SAS. Epi_Pak[3] was used to calculate the 95% confidence intervals.

Results

A single item 1997 question asked the adults, "With the choices your health insurance plan gives you, was it easy to find a personal doctor or nurse you are happy with?" Of the 1,059 who answered this question, 820 said yes, for a 77.4% rate. The child survey question was, "With the choices your child's health insurance plan gives you, was it easy to find a personal doctor or nurse for your child you are happy with?" Of the 1,117 responses, 938 replied yes, for an 84% rate. For 1998, this question was asked as "With the choices your health plan gives you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?"

The response rates of not a problem and a small problem are combined, for comparison purposes, and treated as a yes equivalent to the 1997 question. For the 360 adult respondents the rate was 83.3%, and for the 419 child survey respondents it was 89.7%. The improvement in the child survey is statistically significant for a $P\text{-}value < 0.05$.

The overall rating scale questions asked the person responding to use any number on a scale from zero to 10 where zero was the worst possible and 10 was the best possible. The first question inquired about the perceived quality of health care. For the adult survey the question is "How would you rate all your health care?" The 1,194 responses averaged in 1997 to 7.6. The 562 responses in 1998 averaged to 8.0. The child survey question asked, "How would you rate your child's health care?" For the 1,045 responses in 1997 the average was 8.1. In the 1998 survey, the average was 8.3 for the 762 responses.

Averages for these three overall rating scales are shown in Figure 1. Table 1 lists the averages and standard deviations for all three overall rating scale questions. The Wilcoxon test did not demonstrate a significant difference between the 1997

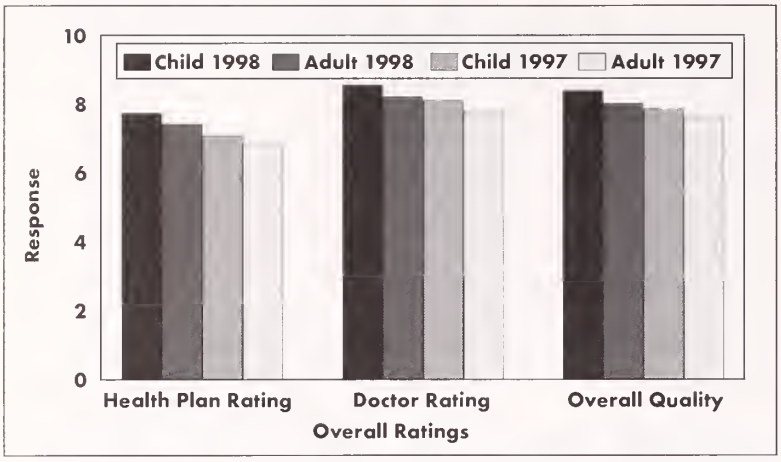


Figure 1. Results of 1997 and 1998 CAHPS® for adults and children, comparing quality of health plan, personal doctor or nurse, and overall quality of health care.

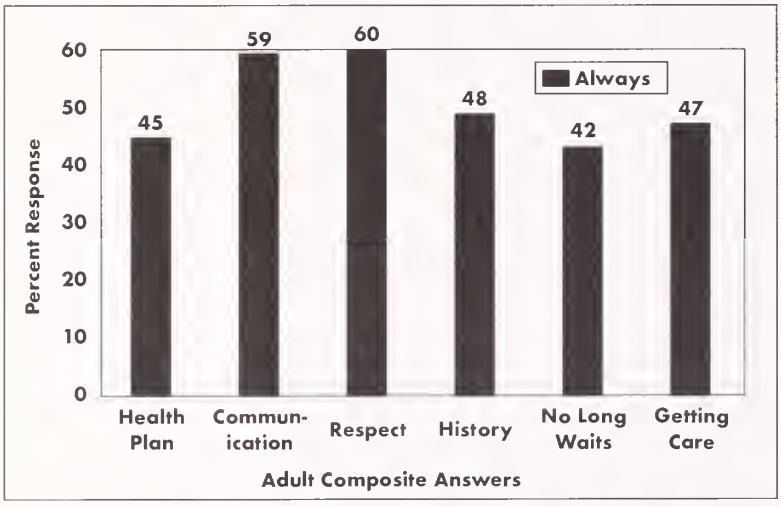


Figure 2. Results of 1997 CAHPS® 1.0 for always response for adults on seven composite questions.

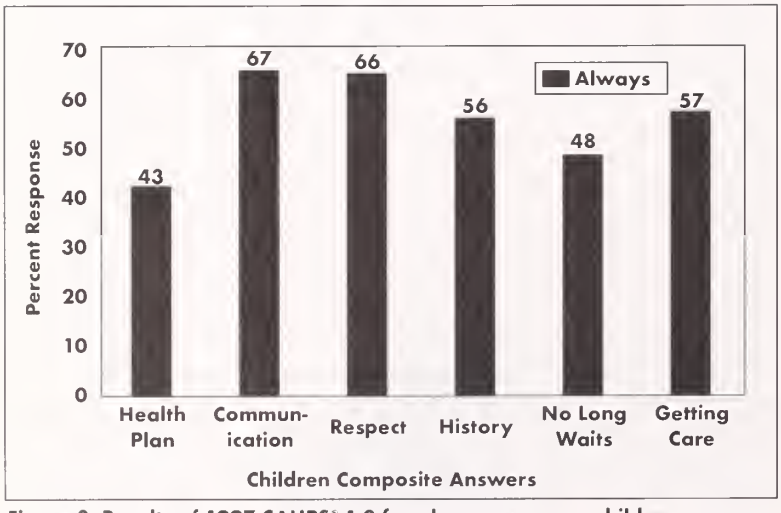


Figure 3. Results of 1997 CAHPS® 1.0 for always response children on seven composite questions.

and 1998 values for either the child or adult survey, even though the 1998 values were higher.

The second question to use the 0-10 overall rating scale was "How would you rate your personal doctor or nurse now?" For 1997, among 932 adult responses the average was 7.9. For 1998 the 483 responses averaged to 8.2 (Table 1). For the child survey the question was "How would you rate your child's personal doctor or nurse now?" For 1997, for the 972 responses the average was 8.3.

For 1998, the 686 responses averaged to 8.4, shown in Figure 1. The Wilcoxon test did not demonstrate a significant difference between the 1997 and 1998 values for either the child or adult survey, although scores were higher in 1998.

For the third question profiled from the 0-10 overall rating scale, the respondents rated their health plan's performance overall. The question was "How would you rate your health plan now?" For the 1,296 adult responses of 1997 (Table 1) the average was 7.4. For the 758 adult responses in 1998 the average was 7.6. The corresponding child question was "How would you rate your child's health plan now?" For the 1279 child survey responses the average in 1997 was 7.8.

For the 992 child survey responses in 1998 the average was 7.9, presented in Figure 1. The Wilcoxon test did demonstrate a significant difference, with $p < 0.05$, between the 1997 and 1998 values for both the child and adult survey, indicating statistically significant improvement.

The multi-item composites combine two or more questions to summarize the responses on similar topics (Table 5). The questions were answered in "how often" format (always, usually, sometimes, and never),or for the "problem" format (not a problem, a small problem, and a big problem). Some items were reverse coded to maintain comparability among the items.

In the 1997 composite "Getting the care you need" (Table 2), of the total 2,920 adult responses, 46.8% responded always (Fig. 2). The child survey questions were similar to the adult (Table 3). For the 2,348 responses, there are 56.6% responding always (see Fig. 3).

For 1998, the questions on getting needed care were in the "problem" response format; Table 4 has the complete data. For the 2,297 responses for the adult survey, 70.8% replied not a problem. For the 1,784 child survey responses, 79.4% replied not a problem (Fig. 4).

The next 1997 composite was on "Getting care without long waits." For the adult survey 3,547 responses were recorded, with 42.4% responding always. For the child survey, the 3,227 responses were broken down into 47.5%

Table 1. 1997 and 1998 Rating Item Results

	1997 Adult			1998 Adult			1997 Child			1998 Child		
Quality of:	N	R	St Dev	N	R	St Dev	N	R	St Dev	N	R	St Dev
Health Plan	1296	7.43	2.59	758	7.61	2.32	1279	7.77	2.44	992	7.88	2.36
Doctor	932	7.92	2.38	483	8.16	2.28	972	8.25	2.28	686	8.44	2.13
Overoll Health Care	1194	7.60	2.47	562	7.99	2.34	1045	8.06	2.33	762	8.29	2.14

Wilcaxan scares ranked sums, far difference between 1997 and 1998, was significant at $p < 0.05$ far anly the averall health care quality averages, far bath the child and adult survey.

Table 1. Average (and standard deviation) of 1997 and 1998 CAHPS® results for adult and child surveys on three identical questions with overall ranking between zero (worst) and 10 (best) as possible answers.

Table 2. Total for Adult Surveys Ranked 1997 and 1998

	Always		Usually		Sometimes		Never	
Composite Question	%	CI	%	CI	%	CI	%	CI
Getting Adequate Care 1997 N=2920	46.8	45-48.6	21.0	19.5-22.5	17.4	16-18.8	14.8	13.5-16.1
No Long Waits For Care 1997* N=3547	42.4	40.8-44.1	28.4	26.9-30	18.9	17.6-20.2	10.3	9.3-11.3
Getting Care Quickly 1998* N=2297	44.1	42-46.2	21.5	19.8-23.3	22.9	21.1-24.6	11.5	10.2-12.8
Medical History 1997 N=2114	47.6	45.5-49.8	25.7	23.8-27.6	18.1	16.5-19.8	8.6	7.3-9.8
Respect and Courtesy 1997† N=2126	59.7	57.6-61.8	23.7	21.8-25.5	12.9	11.5-14.4	3.6	2.8-4.4
Respect and Courtesy 1998† N=1129	67.0	64.2-69.8	20.3	17.9-22.7	10.6	8.8-12.5	2.1	1.2-3
Communicatian 1997* N=3757	59.2	57.6-60.8	20.7	19.4-22	15.5	14.3-16.7	4.6	3.9-5.3
Communicotion 1998* N=3026	62.5	60.7-64.2	21.1	19.6-22.6	12.1	11-13.3	4.3	3.5-5
Health Plan Custamer Service 1997 N=2047	44.9	42.7-47	26.0	24.1-27	20.1	18.3-21.8	9.0	7.8-10.3

* = Questians were similar in bath years
† = Questians were identical in both years

Table 2. Totals for adult surveys ranked questions 1997 and 1998. Percentages may not add to 100 due to rounding. CI is the 95% confidence interval. Most questions in the cluster were changed from CAHPS® 1.0 in 1997 and CAHPS® 2.0 in 1998.

always. For 1998, from the 1,784 responses from the adult survey, 44.1% replied always. For the 2,297 responded from the child survey, 49.3% replied always.

The third 1997 composite asked about "Doctors who communicate well with patients."

For the adults, of the 3,757 responses, 59.2% were always. For the similar questions on the child survey, there were 2,200 responses. Always was reported for a 67.3% rate. For 1998, for the adults, there were 3,026 responses, with 62.5% rate for always. For the child survey there were 2,249 recorded responses, with 70.8% rate for always.

The fourth composite in 1997 asked two questions about "Doctors who spend enough time with patients and know their medical history." In the adult population, there were 2,114 responses, with 47.6% responding always. For the similar child survey questions, 2,008 responses were recorded. Always was recorded for a 56.4% rate. The time question, in 1998, was incorporated into the composite on doctor communication, and the medical history question was not profiled.

The fifth composite 1997 question inquired about "Courtesy, respect, and helpfulness of the medical office staff." In 1998, the questions

Table 3. Total for Child Surveys Ranked 1997 and 1998

Composite Question	Always %	Always CI	Usually %	Usually CI	Sometimes %	Sometimes CI	Never %	Never CI
Getting Adequate Care 1997 N=2348	56.6	54-58.7	18.7	17-20.3	13.5	12.1-14.9	11.1	9.8-12.4
No Long Waits For Care 1997* N=3227	47.5	45.8-49.2	26.7	25.1-28.2	15.8	14.5-17.1	10.0	9-11.1
Getting Care Quickly 1998* N=1784	49.3	46.9-51.6	18.7	16.8-20.5	20.8	18.9-22.7	11.3	9.8-12.8
Medical History 1997 N=2008	56.4	54.2-58.6	25.9	24-27.8	12.5	11-14	5.2	4.2-6.3
Respect and Courtesy 1997† N=2106	66.1	64.1-68.1	20.5	18.7-22.2	10.7	9.4-12.1	2.7	2-3.4
Respect and Courtesy 1998† N=1529	72.9	70.6-75.1	16.8	14.9-18.7	8.6	7.2-10.1	1.7	1-2.4
Communication 1997* N=2200	67.3	65.3-69.3	21.0	19.3-22.8	8.6	7.4-9.8	3.1	2.3-3.8
Communication 1998* N=2249	70.8	68.9-72.7	16.7	15.2-18.3	9.7	8.4-10.9	2.8	2.1-3.6
Health Plan Customer Service 1997 N=1565	42.7	40.2-45.2	26.6	24.4-28.8	20.6	18.7-22.7	10.1	8.6-11.6

* = Questions were similar in both years
† = Questions were identical in both years

Table 3. Totals for child surveys ranked questions 1997 and 1998. Percentages may not add to 100 due to rounding. CI is the 95% confidence interval. Most questions in the cluster were changed from CAHPS® 1.0 in 1997 and CAHPS® 2.0 in 1998.

Table 4. Composite Item Responses 1998 Adult and Child CAHPS® Study

Composite Item		N	Not a Problem %	Not a Problem CI	A Small Problem %	A Small Problem CI	A Big Problem %	A Big Problem CI
Getting Adequate Care	Adult	1712	70.8	68.6-72.9	16.1	14.3-17.9	13.1	11.5-14.7
	Child	2129	79.4	77.7-81.2	12.6	11.2-14.0	8.0	6.8-9.2
Health Plan Customer Service	Adult	899	60.8	57.6-64.1	26.4	23.4-29.3	12.8	10.6-15.0
	Child	957	63.2	60.1-66.3	12.8	10.6-14.9	24.0	21.3-26.8

Table 4. 1998 CAHPS® 2.0 results for both adult and child surveys on the ease of getting adequate care and ease of getting assistance from the health plan customer service. CI is the 95% confidence interval.

were identical. For the adults in 1997, of the 2,126 responses, 59.7% were always. For the adults in 1998, the 1,129 responses had 67.0% always. The child survey had 2,106 responses in 1997, with 66.1% always. For 1998, the child survey had 1,529 responses, with 72.9% always. The Wilcoxon test did demonstrate a significant difference, $p < 0.0001$, between the 1997 and 1998 values for both the child and adult survey.

The sixth 1997 composite asked three questions on the "Health plans' customer service: efficiency and helpfulness." For the adults, 2,047 responses were recorded, with 44.9% always. The child survey had 1,565 responses with 42.7% always responses.

For 1998 in CAHPS® 2.0, the health plan customer service was also analyzed with three questions. For the 899 adult responses, not a problem was recorded 60.8% of the time. For the 957 child survey responses, not a problem was recorded for 63.2%.

The overall rating scale questions in the Children with Special Needs Survey asked the person responding to use any number on a scale from zero to 10 where zero was the worst possible and 10 was the best possible. The first question was "How would you rate your child's personal doctor or nurse now?" For the group,

the average was 7.5. The second question to use the 0-10 overall rating scale was "How would you rate your child's specialist?" The average was 8.6.

The third question inquired about the perceived quality of health care. The survey question asked "How would you rate your child's health care?" For the responses in the special needs population, the average was 8.2.

The fourth question for the numeric rating scale for the special needs population was "How would you rate your child's treatment or counseling now?" The average was 7.5. The fifth question profiled from the 0-10 overall rating scale, the respondents rated their health plan's performance overall. The question was "How would you rate your child's health plan now?" For the special needs child survey responses, the average was 7.8.

Only one rating scale was used in the PACBHS. It asks the respondent to "Please rate the mental health care your child has received in the last six months from all treatment clinicians combined." The average was 7.4. A follow-up question asked "Would you recommend your child's main mental health clinician to someone else who needs help?" Of the respondents, 73.2% answered yes and 15.6% replied maybe.

For the special needs population, the questions on getting needed care were in the "problem" response format. The questions were identical to the 1998 general CAHPS® (Table 5). For the survey responses, 72.3% replied not a problem. The next composite was on "Getting care quickly." The questions were identical to the 1998 "Getting care without long waits" (Table 5). For the responses from the special needs child survey, 56.5% replied always.

The third composite asked about "Doctors who communicate well with patients." The questions were the same as the general survey for 1998 (Table 5). For the special needs child survey, a 55.2% rate for always was recorded. The fourth composite question inquired about "Courtesy, respect, and helpfulness of the medical office staff." Again, these were identical to the 1998 questions in the same area. For the special needs population the survey had a 65.9% always. The last composite, in reference to the health plans, asked two questions on helpfulness and efficiency. For the group with special needs, a 22.0% always rate was recorded.

For the pediatric adaptation of the adult behavioral health survey, there were three questions, with two as composites. The first composite asked the respondents about getting care quickly, with 61.9% answering always. The second composite inquired about the adequacy of communication, respect, and time from the clinician, with 69.9% responding always. The questions are identical to those of the special needs population survey on the same topics (Table 5). The third question asked how much was the child helped by treatment, with 21.5% answering "a great deal," 33.9% "quite a bit," and 9% "not at all." The follow-up question was on recommending the clinician to another patient, with 11.2% saying they would not.

Response rates for the two special populations differed, with the special needs rate being higher than both the behavioral health sample and the general CAHPS® child survey samples. Behavioral health response rates were comparable to the general CAHPS® child survey samples. Adjusted response rates were calculated following CAHPS® methodology. The rates were 63% for the special needs population and 48% for the behavioral health sample. The general CAHPS® child survey rates were 49% and 53% for the urban and rural samples.

Discussion

The baseline study of 1997 highlighted areas for potential improvement and strengths in the SoonerCare Plus Program. It provided the OHCA program and the health plans with useful information for program enhancement. The 1997 report also provided the basis for a "report card" of plan performance, which was sent to Medicaid recipients making HMO selections during the 1998 open enrollment period.

The 1998 follow-up study demonstrated areas of significant improvement from the 1997 baseline and allowed plans to compare their performance, as measured by their members' responses, against their peers. The 1998 survey also allowed the plans to compare their performance in some areas against the 1997 baseline. The 1998 analysis provided the basis for a "report card" of plan performance, which was sent to Medicaid recipients making HMO selections during the 1999 open enrollment period.

Statistically significant areas of improvement were achieved in the two general surveys in the overall rating for the health plans for both the adult and child survey. The office staffs had statistically significant improvement in the area of courtesy and respect for the adult and pediatric patients, as measured from one survey to the second. The third area of statistical significant improvement was the ability to find a satisfactory physician for the care of the child.

Table 5. Questions asked for similar topics, grouped in clusters. Questions were reverse coded as needed for comparability of answers within a cluster

Getting the Care you Needed in 1997

In the lost six months, how often did you hove to see someone else when you wonted to see yaur persanal dactar ar nurse?

In the lost six months, how often did you see o speciolist when you thought you needed ane?

In the lost six months, how often did you get the medicol help or advice you needed when you phoned the doctor's office or clinic during the day Manday ta Fridoy?

In the lost six months, how often did you get the tests or treotments you thaught yau needed?

Getting the Care you Needed in 1998

With the chaices your health plon gives you, how much of o problem, if ony, wos it to get o personal doctor ar nurse yau are happy with?

In the lost six manths, haw much of o problem, if ony, wos it to get o referrol to o speciolist that you needed to see?

In the lost six manths, haw much of a prablem, if ony, wos it to get the core you or your doctor believed necessory?

In the lost six months, haw much af a prablem, if ony, were deloys in health care while you woited for opprovol from your health plon?

Getting Care Without Long Waits 1997

In the lost six manths, how often did you get the medicol help ar advice during the doy Monday ta Fridoy withaut o long woit?

In the last six manths, when you tried to be seen for on illness or injury, how often did you see o doctor or other health prafessianal os saan os you wonted?

In the lost six months, when you needed regulor or routine health care, how often did you get on oppaintment os saan as you wonted?

In the lost six manths, haw aften did you woit in the doctor's office ar clinic mare thon 30 minutes post your oppointment time ta see the person you went to see?

Getting Care Without Long Waits 1998

In the lost six months, when yau colled during regulor office hours, how aften did yau get the help or advice you needed?

In the lost six months, when you tried to be seen far an illness ar injury, how often did you see a dactar ar ather health professionol os soon os yau wanted?

In the last six months, when you needed regular ar routine heolth core, how often did you get on appaintment os soon os you wonted?

In the lost six manths, how often did you woit in the doctar's office mare than fifteen minutes post your oppaintment time to see the person you went to see?

Doctors Who Communicate Well with Patients 1997

In the lost six months, haw aften did doctors or other health profes-sianals listen carefully to you?

In the lost six months, haw aften did dactars or other heolth profes-sionols explain things in o woy yau could understond?

In the last six months, how often did dactars or other heolth profes-sionols show respect far what yau hod to soy?

In the lost six manths, haw often were you invalved as much os you wonted in these decisians obaut yaur heolth core?

Doctors Who Communicate Well with Patients 1998

In the lost six months, haw aften did doctors ar ather heolth profes-sianals listen corefully to you?

In the lost six months, haw aften did doctors or other health profes-sianals explain things in o woy you cauld understond?

In the lost six months, how often did dactars ar ather heolth profes-sionals shaw respect far what yau hod to soy?

In the last six months, how often did doctors or other heolth praviders spend enough time with yau?

Doctors Who Spend Enough Time With the Patient and Know Their Patient's Medical History 1997

In the lost six manths, how aften did dactars ar ather heolth profes-sianals spend enaugh time with you?

In the lost six manths, how aften did dactars ar ather health profes-sionols know whot you thought they should know obout your med-icol history?

Courtesy, Respect and Helpfulness of the Medical Office Staff 1997 and 1998

In the lost six manths, haw often were affice stoff ot o doctor's affice or clinic os helpful os you thought they should be?

In the last six manths, how often did the office stoff ot a doctar's office or clinic treot you with courtesy ond respect?

Health Plan's Customer Service: Helpfulness and Efficiency 1997.

In the lost six months, how often were your colls to the heolth plan's customer service token care af without o lang woit?

In the last six manths, how often did you get oll the infarmotian or ather help you needed when yau called the health insuronce plon's cus-tamer service?

In the lost six months, how aften were the peaple ot the heolth insur-once plon's custamer service os helpful os you thought they shauld be?

Health Plan's Customer Service: Helpfulness and Efficiency 1998

In the lost six manths, haw much of o problem, if ony, was it ta find or understond informotion in the written materiols?

In the lost six months, haw much of o problem, if ony, was it ta get the help yau needed when you colled yaur heolth plon's customer ser-vice?

In the lost six manths, how much of o prablem, if ony, did you hove with paperwork for your heolth plan?

Health Plan's Customer Service: Helpfulness and Efficiency 1998 Special Needs Child Survey.

In the lost six manths, how often could yau find the informotion need-ed in the written moterials from yaur child's health plan?

In the lost six months, how often did you get the help you needed when you colled the heolth plon's custamer service?

Getting Care Without Long Waits 1998
Pediatric Adaptation of the Behavioral Health Survey

How often did yau get the help ar advice you needed far yaur child os saan os you needed it when your child wos in o crisis or emer-gency situotion?

Haw aften did your child get an oppaintment with a mentol health clin-icion os soon as yau wonted?

How often did your child woit more thon 20 minutes post the appaint-ment time to see the person your child went to see?

Many areas of numeric improvement did not reach the statistically significant values. Another limiting aspect was the change in the questions from one year to the second, precluding the ability to perform valid statistical comparisons. The improvement by the health plans and providers from the baseline year of 1997 to the remeasured year (1998), both adult and child, reflects the commitment to continuous quality improvement by the health plans and the providers. With areas identified, measurable improvement was noted, and action was taken. Areas for further and continuing effort in improvement were also provided to the OHCA and the health plans by the report in 1998 and the baseline studies of 1999.

While not directly comparable, since the survey items were not the same, the special needs respondents generally indicate higher satisfaction with quality of health care and behavioral health respondents indicated higher levels of satisfaction with timeliness and communication items. Both surveys of special populations were lower than the responses similar questions in the general CAHPS® child surveys for the managed care populations. [J]

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SPECIAL

State of the State's Health: Still on the Decline

Jay A. Gregory, MD, FACS

"The Board of Health believes that the leading causes of our situation are economic, lack of access to adequate health care, educational levels of our citizens, and inadequacy of community health resources."

The Oklahoma State Board of Health has released its fourth Annual *State of the State's Health Report*. It should come as no surprise that the overall health of our citizens remains poor. In a departure from its first three reports, the Board recommends solutions in an attempt to correct the state's health.

Behavioral Risk Factors lead the list of poor health indicators. Oklahoma equals or exceeds the national averages in lack of seat belt usage, lack of exercise, obesity, and tobacco usage. Oklahomans annually consume 111.8 packs of cigarettes per capita compared to the national average of 86.9. Motor vehicle accidents kill 24 per 100,000 in Oklahoma, compared with 16.2 per 100,000 for the remainder of the nation. Fifty percent of our homes have firearms readily available, which may in part explain our high rates of suicide and homicide. Our unwanted teenage pregnancies remain a huge problem leading to poverty and poor health for many of our children.

Within our state there are wide variations between the counties, as well as between gender and race groups. This year's report contains county specific data, which is quite revealing in many instances. It is hoped that this county specific data will serve as a starting point for discussions within local communities, which in turn will lead to solutions that improve our state of health.

The Board of Health has discussed often the underlying reasons for our poor health statistics. The Board believes that the leading causes of our situation are economic, lack of access to adequate health care, educational levels of our citizens, and inadequacy of community health resources.

It is quite apparent that there is a lack of adequate preventive services in Oklahoma. The Oklahoma Foundation for Medical Quality has launched educational programs to educate physicians on preventive measures for heart attack and stroke. The Oklahoma State Medical Association has embarked on its Physicians' Campaign for a Healthier Oklahoma. This program delivers a healthy message for patients through participating physicians. The Oklahoma Turning Point Initiative has been piloted in three counties and can serve as a template for local communities in addressing their health problems.

"An ounce of prevention is worth a pound of cure." The most powerful prevention can be delivered at the point of service, the physician's office. It is crucial for physicians to lead the way for improving the health of all Oklahomans.

In the end, it is very apparent to the Board that none of these efforts can or will be successful unless the hallmarks of any effort are cooperation and collaboration between key groups within local communities. Any effort at the local level must involve local physicians, the business community, public health professionals, state government, the faith leaders, and other key community leaders. It is imperative that we start today. We can wait no longer.

Change is difficult for all human beings, but we must rethink how we approach preventive medicine, we must coordinate all our efforts, and we must collaborate with all interested parties if we are to be successful on behalf of the citizens of Oklahoma.

A copy of the *2000 State of the State's Health Report* can be obtained from the Oklahoma Department of Health. The entire report can be found on the Internet at the following location: www.health.state.ok.us/board/state/index.html.

The Author

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Thousands Respond to OSMA Take Care Campaign

As director of the Emergency Medical Services in Prague, OK, Nathan Wiggins knows how vital a patient's medical history is for ambulance personnel when they are called to the scene of an emergency. When EMS paramedics arrive at the home of an elderly person, one of their immediate needs is finding out what, if any, medications the patient is taking and whether or not the person has a chronic medical condition.

Their job of stabilizing and moving the patient safely to the hospital is often made more difficult because no one can provide that information, Wiggins said.

"Generally, when we get to a scene, when you ask them for a list of their medications — even if there is a relative there — they don't know what or where the medications are, or they know some of the medications but not all of them," Wiggins said. "They don't know the patient's medical history, and I think it would be very beneficial to us to know that patient history once we get there."

Often, even patients themselves have little knowledge about the medications that have been prescribed for them, he said. "They may say something like 'I take the green pill four times a day, and I take the pink pill once,'" Wiggins said.

But Wiggins sees some help for himself and other EMS personnel across the state in the Take Care vials that are being distributed throughout Central and Western Oklahoma by the OSMA. A project of KWTV - Channel 9 and co-sponsored by the OSMA and Physicians' Campaign for a Healthier Oklahoma, the Take Care Campaign was designed to save lives by putting medical information in a place where it can easily be found in time of emergency.

The vials contain a medical history information form that recipients fill out and then store inside their refrigerator. A sticker is included that can be placed on an entrance door to alert emergency personnel that the medical information vial is available.

"I think it would be real beneficial to EMS once they get on the scene," Wiggins said. "I think it's a good deal for us and the patient both. It's a good deal for all concerned."

Wiggins discovered the availability of the Take Care vials through an acquaintance who saw it on KWTV's Internet site. KWTV broadcast promotional spots and news features about the Take Care Campaign throughout much of January. Wiggins contacted OSMA headquarters and ordered 150 of the vials to distribute to senior citizens in his community.

Wiggins' reaction to the Take Care campaign was played out hundreds of times in January and February after the program was aired on KWTV. More than 7,000 of the vials were quickly distributed to physicians' offices, churches, senior citizen programs and organizations throughout the western half of the state. Take Care vials were distributed in a similar fashion in eastern Oklahoma in late 1999 when the campaign was aired by co-sponsor KOTV-Channel 6 in Tulsa.

During the most recent campaign, more than three dozen Oklahoma physicians in Central and Western Oklahoma ordered Take Care vials to distribute to their patients. Their office locations ranged from Ponca City to the north to Altus in the southwest, with many points in between.

Meanwhile, vials were made available to organizations as varied as the Oklahoma Department of Human Services, Greater Oklahoma City Chamber of Commerce, Superbia Retirement Village, Mayfair Church of Christ, Seminole County Elder Care, Fletcher 4-H Club and many others. Each had the same intent: to put the Take Care vials into the hands of people who needed them.

At the Superbia Retirement Village in Oklahoma City, Associate Director Diane Blaney said one of the independent living center's residents brought a Take Care vial into her office. Blaney looked it over and then ordered enough for every Superbia resident.

"We urge our residents to have something in their apartments that has their emergency numbers on it and their medications, but it's so hard to monitor that because we don't have enough staff," she said. "We thought this was a good opportunity to encourage people to keep an accurate list. Sometimes that's really hard for older people to do. This is a good way to get them to focus on that and to have it available if they should have an emergency. That's the first thing the EMSA guys ask for — 'what medicines are they taking?' Usually, it's one of us from the office who are there with them after they've called and we don't know. We're not doctors, we're not nurses.

"It's really helpful if they've got something that spells that out for those people."

In Wewoka, Joy Greenlee, In-Take Coordinator for the Seminole County Elder Care program, ordered two boxes of the vials and worried that more are needed for senior citizens in her community. There is a real need for them, she said.

"I had been calling around to some of the elderly in this area to see if they had any needs that we could help them with," she said. "I had a couple of them tell me they had heard about these bottles and wanted me to find out if I could locate them because they would like one."

The Take Care message spread quickly. Greenlee said her counterpart in Hughes County heard of the campaign and was making plans to distribute them among the elderly there.

In Shawnee, Dorothy Hopkins is Project Chairman for the local chapter of the American Association of Retired Persons. She ordered the Take Care vials for her fellow AARP members because she knows how vulnerable they are to a medical emergency. "We're all pretty conscious about those things," she said. "I just lost my husband last year."

Among the many orders for the Take Care vials was one placed by the 4-H Club in Fletcher, OK. Mollie Chaney, 15, is President of the Fletcher 4-H Club. She saw the Take Care presentation on Channel 9 and decided it would be a worthy project for her organization's Phone Pal program. The Fletcher 4-Hers have "adopted" elderly residents in their community, keeping in touch with them and providing assistance where they can. "I feel this will be a plus for the senior citizens in our area," Mollie said. "Most of the people that we are in contact with live alone and range from the age of 60 to over 90."

The Fletcher 4-H Club planned a workshop to explain the Take Care vials before they were to be distributed. Mollie said the distribution of the Take Care vials provided another important contact between the 4-H Club members and their phone pals.

"I felt that it would add to our Phone Pal program and add a sense of security for the senior citizens that are a part of the program," she said.

It's a sense of security that OSMA officials hope thousands of Oklahomans now have through the Take Care campaign.



Superbia Retirement Village resident Hazel Milne, left, and Associate Director Diane Blaney display one of the Take Care Vials inside Milne's apartment.

News

OSMA Leaders Emphasize Signifcance of Health Report at Briefing

OSMA leaders took a key role on February 3 when the 2000 State of the State's Health Report was released in a media briefing at the State Capitol.

Boyd O. Whitlock, MD, OSMA President, and Robert J. Weedn, MD, President-elect, joined Jerry R. Nida, MD, State Health Commissioner; Jay A. Gregory, MD, State Board of Health President, and Gordon H. Deckert, MD, Board of Health member and spokesperson for the OSMA's Physicians' Campaign for a Healthier Oklahoma, in outlining the findings of the report at the briefing.

The report showed that the collective health of Oklahomans continued a steady decline in 1999 and proposed solutions to halt the erosion.

Each of the medical leaders addressed the audience, summarizing the report and discussing proposed responses to the data.

Dr. Weedn described the goals of the Physicians' Campaign for a Healthier Oklahoma, which is intended to encourage physicians to implement educational measures for their patients.



Television cameras focus on Dr. Jay Gregory, President of the Oklahoma State Board of Health, as he discusses the 2000 State of the State's Health Report on February 3 in the Blue Room of the State Capitol.

"We in the medical community have a responsibility to treat patients but also to teach people about lifestyle options," Dr. Weedn said. "We must promote wellness."

Dr. Whitlock said that the OSMA's top legislative priority is the establishment of a trust fund in order to put the state's share of the tobacco settlement money to use addressing tobacco-related health care problems.



EVENING OF EXCELLENCE: *(from left) Drs. Robert McCaffree and Mary Anne McCaffree, Immediate Past President of the OSMA; Kathy Musson, Associate Executive Director of the OSMA; Dr. Gary Strebel, Vice President of the OSMA; and Mrs. Sherry Strebel pose with a plaque honoring Dr. Edward N. Brandt, Jr., at the annual Evening of Excellence Awards dinner January 20 in Oklahoma City. Dr. Strebel co-chaired the event, and Dr. Mary Anne McCaffree introduced Dr. Brandt.*

News Briefs

Dr. Morris Reichlin, Vice President of Research and Scientific Director at the Oklahoma Medical Research Foundation, was recently named winner of the Lee C. Howley Sr. Prize for Arthritis Research at the annual House of Delegates Meeting of the Arthritis Foundation. Among his many notable research achievements, Dr. Reichlin discovered and characterized some of the most important autoantibodies in the autoimmune rheumatic diseases.

Dr. Jack L. Gregston, a family physician from Marlow, was recently honored for 35 years of membership in the American Academy of Family Physicians.

Informational Tour Takes Physicians' Campaign for a Healthier Oklahoma to County Medical Societies

County by county, Oklahoma physicians are learning the details of the OSMA's Physicians' Campaign for a Healthier Oklahoma. OSMA leaders have been making presentations at county medical society meetings throughout the state, discussing the purpose and strategy of the campaign, as well as the reasons behind it.

As the annual State of the State's Health Report continues to show, the collective health of Oklahomans declined throughout the 1990s at a time when the health of citizens in virtually every other state has improved. Concern over those statistics inspired OSMA leaders to organize the Physicians' Campaign as a way to give Oklahoma physicians the tools they need to help their patients choose healthier lifestyles.

The Physicians' Campaign presentations at county medical societies are continuing this spring, with two programs scheduled for March. OSMA officials will make a presentation to the Kay County Medical Society at 6:45 p.m. on March 14 in Ponca City. Another presentation is scheduled for 7 p.m. on March 16 to the Pittsburgh County Medical Society in McAlester. Other presentations are pending.

For information about scheduling a presentation in your area, call Joy Leuthard, Director of Health Care Policy & Research at 800/522-9452 or 405/843-9571.



Robert J. Weedn, MD, OSMA President-elect, second from left, talks with members of the Carter-Love-Marshall County Medical Society after his presentation on the Physicians' Campaign for a Healthier Oklahoma in Ardmore on January 11.

AMA Alliance Notes March Health Observances

March commemorates much more than St. Patrick's Day, especially for the health care community. Here are some key March events, as noted by the AMA Alliance. Month-long designations include:

- Hemophilia Awareness Month
- Eye Donor Month
- National Nutrition Month
- National Juvenile Arthritis Awareness Month
- National Workplace Eye Health and Safety Month
- National Chronic Fatigue Syndrome Awareness Month
- Mental Retardation Awareness Month
- National Kidney Month
- National Social Work Month

Other March observances include: Shamrocks Against Dystrophy for the Muscular Dystrophy Association, March 1-17; National Save Your Vision Week, March 4-10; National School Breakfast Week, March 6-10; Pulmonary Rehabilitation Week and Children and Healthcare Week, March 12-18; Brain Awareness Week, March 13-19; and National Poison Prevention Week, March 19-25.

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Oklahoma State Medical Association
Oklahoma State Medical Association Alliance
94th Annual Meeting

May 4-7, 2000



Physicians' Campaign For A Healthier Oklahoma

THE WESTIN
OKLAHOMA CITY
One North Broadway

Registration information for Delegates will be mailed the second week of March.

MEETING SCHEDULE

Thursday, May 4, 2000

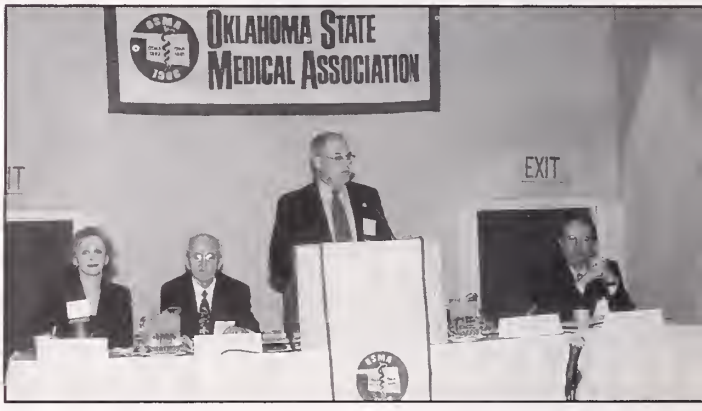
9:30 am	OSMA Executive Committee Meeting
Noon	OSMA Executive Committee/Board Luncheon
1:30 pm	OSMA Registration Opens
5:00 pm	"Women in Medicine" Reception
5:00 pm	Speakers' Pre-Convention Meeting
5:00 -6:30 pm	Organized Medical Staff Section Meeting (OMSS)
6:00 pm	*OSMA Loss Prevention Seminar*

Friday, May 5, 2000

6:00 am	Hospitality
7:00 am	OSMA/OSMAA Registration Opens
7:30 am	Tulsa, Oklahoma & Rural County Medical Societies Caucus & Breakfast
7:30 am	Credentialing for House of Delegates
8:00 am	OSMA Exhibits & AMA-Foundation Silent Auction Open
8:30 am	OSMA House of Delegates Opening Session
noon	OSMA/OSMAA Luncheon — Abraham Verghese, MD
1:00 pm	OSMA Reference Committee I
2:00 pm	OSMA Reference Committee II
2:30 pm	OSMA Reference Committee III
2:00 pm	*OSMA Alliance Decorators' Showhouse Tour/Tea*
6:00 pm	*Oklahoma Surgical Association Party*
6:00 pm	OSMA/OSMAA Presidents' Reception **Cowboy Hall of Fame**
7:00 pm	OSMA/OSMAA Presidents' Inaugural Banquet **Cowboy Hall of Fame**

Saturday, May 6, 2000

6:00 am	Hospitality
7:00 am	OSMA/OSMAA Registration Opens
7:00 am	County Society Presidents,' Specialty Society Presidents,' and OSMA Past Presidents' Breakfast
7:00 am	OSMA Breakfast Forums
7:30 am	*Alliance State County Society Presidents' and Presidents'-elect Breakfast*
8:00 am -5:00 pm	Continuing Medical Education programs
9:00 am	Alliance House of Delegates
10:00 am - 1:00 pm	*Oklahoma State Orthopaedic Society Luncheon/Business Meeting*
Noon	Legislative Luncheon Box lunches provided
1:30 pm	OMPAC General Membership Meeting
2:30 pm	Myriad Gardens/Canal Tour
6:00 pm	*Medical Alumni Assn., University of Oklahoma*
8:30 pm	*Annual Reception & Dinner*
9:00 pm	*Medical Alumni Association, University of Oklahom Class Reunions*



Exhibitors/Sponsors

The Exhibitors and Sponsors play a vital role in contributing to the overall success of the Annual Meeting. Through their generous financial support, the OSMA is able to provide attendees with quality educational programs and enjoyable social functions. Exhibitor booths are open Friday, May 5, from 8:00 a.m. - 5:00 p.m. and Saturday, May 6, from 8:00 a.m.-2:00 p.m.

★ Specialty Billing Services ★ Alterra ★ Ortho-McNeil ★ Physician Manpower Training
★ Mind Body & Spirit Institute-Integris Baptist Medical Center ★ Research Solutions LLC
★ James Baker & Associates ★ Janssen Pharmaceutical ★ C.L. Frates ★ Merck Human Health
★ Integris Mental Health ★ OMPAC ★ OSMA Physicians' Campaign for a Healthier Oklahoma
★ Oklahoma County Medical Society ★ Barnes & Noble Bookstore ★ Stillwater National Bank
★ CCI Technologies ★ OUHSC College of Public Health ★ Second Chance Technologies
★ Harrison Peck Associates, PC ★ McNeil Consumer Healthcare ★ Guaranty Bank

OTHER ACTIVITIES

OSMA/OSMA Alliance Luncheon and Book Signing

Friday, May 5 **noon**

Dr. Abraham Verghese is a professor of medicine at Texas Tech University and the author of *My Own Country* and *The Tennis Partner*. He lectures on the medical humanities to medical groups, and his essays and short stories have appeared in *The New Yorker*, *Granta*, and other publications. (Book signing immediately following)

Cost $35.00 per person (does not include cost of book)



Abraham Verghese, MD

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OSMA/OSMA Alliance Inaugural

Friday, May 5 **6:00-10:00 p.m.**

The Cowboy Hall of Fame will be the location for the inauguration of Robert J. Weedn, MD, as OSMA President and Mary Ann Couch as OSMA Alliance President. The evening will begin with a reception at 6:00 p.m. followed by a dinner at 7:00 p.m. (See the April issue for more information regarding keynote speaker)

Cost $60.00 per person

OSMA Legislative Luncheon

Saturday, May 6 **Noon**

OSMA Federal Lobbyist John Montgomery and representatives from the AMA's Washington office will provide an update on the Patients' Bill of Rights, antitrust legislation, and other health issues being debated on Capitol Hill. OSMA State Lobbyists Lynne White and Dan Draper will also discuss key state legislative issues, as well as provide an update on the proposed uses of Oklahoma's tobacco settlement funds. No charge for the luncheon; ***however, a reservation is required.***

OSMA Alliance Decorators' Showhouse Tour/Tea

Friday, May 5 **2:00 p.m.**

Alliance members and guests are invited for a tour of the Decorators' Showhouse and a "High Tea." This year's "mission style" home, located at 3205 NW19th Street in the Linwood Addition, was designed by the same architect who designed the State Capitol and the Skirvin Hotel. Members at Large will be our special guests for this fun afternoon.

Cost $20.00 per person

Breakfast Forums

Saturday, May 6 **7:00-8:00 a.m.**

The OSMA will sponsor two breakfast forums on Saturday morning:

- ✓ "Breakfast with Medicare" - Mayo Gilson, MD, Medical Director, Medicare Services
- ✓ Oklahoma Board of Medical licensure - Panel discussion regarding the CME Licensure requirements for physicians.

No charge for the forums, however a reservation is required.

CME PROGRAMS

THURSDAY, MAY 4, 2000

OSMA/ERF Loss Prevention Program - 2 hours

SATURDAY, MAY 6, 2000

Chemical Dependency: The Disease
2 hours
8:00 a.m.-10:00 a.m.

Cardiovascular Program - 2 hours
10:00 a.m. - Noon

Contract Review - 2 hours
1:00 pm - 3:00 pm

Cancer Genetics - Ethics and the Law
2:00 pm - 3:00 pm 1 hour

Legal Compliance - 1 hour
3:00 pm - 4:00 pm

HCFA National Projects - 1 hour
4:00 pm - 5:00 pm

More detailed information regarding speakers and course objectives will follow in the March OSMA newsletter and April OSMA Journal.

Myriad Gardens/Bricktown Water Canal Tour

Saturday, May 6 **2:30 p.m.**

OSMA Physicians and Alliance members are invited to join The Physicians' Campaign for a Healthier Oklahoma for a complimentary tour of the Myriad Botanical Gardens with a Bricktown water canal taxi tour immediately following.

No charge for the tour; however a reservation is required.

Registration

2000 Annual Meeting of the Oklahoma State Medical Association and the OSMA Alliance
May 4-7, 2000, Westin Hotel, Oklahoma City

❑ Delegate ❑ Alternate Delegate ❑ Alliance ❑ Other

Name:_____Spouse: (if attending)_____Guest:_____

Telephone:_____Fax:_____e-mail:_____

Street:_____

City:_____State:_____Zip:_____

Submitting the above information allows the OSMA to have a name badge printed for you and your spouse/guest.

After completing this form, please mail to: Michele Smith, Annual Meeting Registrations, OSMA, 601 W. I-44 Service Road, Oklahoma City, Oklahoma 73118 or fax to (405) 842-1834.

Ticket Reservation

		Quantity
OSMA/OSMAA Luncheon	$35.00 per person	_____
OSMA/OSMAA Inaugural	$60.00 per person	_____
Alliance Decorators Showhouse	$20.00 per person	_____
Breakfast Forums	"No Charge"	
Medicare		_____
Board of Medical Licensure		_____
Reservations required		
CME Programs	"No Charge"	
Substance Abuse		_____
Cardiovascular		_____
Contract Review		_____
Legal Compliance		_____
Reservations required		
Washington/Legislative Luncheon	"No Charge"	_____
Reservations required		
Myriad Gardens/Canal Tour	"No Charge"	_____
Reservations required		

Tickets will be held at the OSMA/OSMAA registration desk to be picked up when you register.

Hotel Information

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Hotel reservations must be made directly with the Westin by ***April 12, 2000***. After that date, OSMA meeting rates cannot be guaranteed. Please mention the ***Oklahoma State Medical Association*** to receive the special group rate.

Room rates are as follows:

Single/Double	$79.00
Triple	$89.00
Quad	$99.00

If you wish to reserve a suite, contact Michele Smith at the OSMA Headquarters for availability (405) 843-9571.

As a member of the OSMA, you may attend many of the events at no charge. Please indicate if you will be attending the no-charge events. This will allow the OSMA to be cost efficient with food and beverage orders.

Charles E. Cook, Jr., MD
1917-2000

Charles E. Cook, Jr., MD, died January 13, 2000. Dr. Cook was born July 29, 1917, in McAlester, Oklahoma. He received his medical degree in 1942 from Oklahoma University School of Medicine. Dr. Cook was a life member of the Oklahoma State Medical Association.

Lynn H. Harrison, MD
1912-2000

Lynn H. Harrison, MD, died January 16, 2000. Dr. Harrison was born in Cortez, Colorado, on October 18, 1912. He graduated from the University of Oklahoma College of Medicine in 1940 and was a life member of the Oklahoma State Medical Association.

Kenneth C. Hoffman, MD
1927-2000

Kenneth C. Hoffman, MD, a life member of the Oklahoma State Medical Association, died January 17, 2000. Dr. Hoffman was born in Harvard, Nebraska, on September 24, 1927, and graduated from the University of Nebraska College of Medicine in 1952.

Donald Charles Barney, MD
1931-2000

Donald Charles Barney, MD, died January 4, 2000. Dr. Barney was born in Vici, Oklahoma, on November 4, 1931. He received his medical degree from the University of Oklahoma School of Medicine in 1958 and was a member of the Oklahoma State Medical Association.

Richard E. McDowell, MD
1920-2000

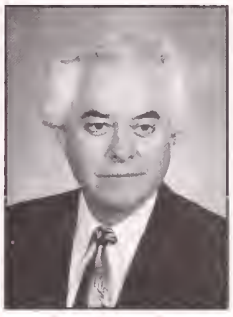
Richard E. McDowell, MD, died on January 17, 2000. Dr. McDowell was born in Bradford, Pennsylvania, on July 23, 1920. He graduated from the University of Buffalo Medical School in 1943 and was a life member of the Oklahoma State Medical Association.

Harry L. Deupree, MD
1908-2000

Harry L. Deupree, MD, died on February 3, 2000. Dr. Deupree, a life member of the Oklahoma State Medical Association, was born in Olney, Illinois, on August 17, 1908. He graduated from the Oklahoma Medical School in 1936 and served in the U.S. Navy during WWII.

Bob Jones, Executive Director of State Osteopathic Association, Dies

Oklahoma medicine lost a friend on February 3, 2000, when Bob E. Jones, longtime Executive Director of the Oklahoma Osteopathic Association, died after a lengthy illness.



Bob's abilities and accomplishments, personally and professionally, were recognized many times. He was the recipient of the American Osteopathic Association's highest award, the Distinguished Service Certificate; Outstanding and Distinguished Service Award from Oklahoma State University College of Osteopathic Medicine; Distinguished Service Award from the American College of Osteopathic Family Physicians; Outstanding and Distinguished Service Award from the Oklahoma Osteopathic Association; Outstanding and Distinguished Service Award from the Arkansas Osteopathic Medical Association; George Nigh Association Executive of the Year Award; 1999-2000 Millennium Award from the Auxiliary to the AOA, and Award of Appreciation from the USO for public service and entertaining armed forces in military hospitals in the Pacific in 1969-1970.

He was the author of the books *The Difference a DO Makes* and *Osteopathic Medicine: The Premier Profession.*

Bob's love for the osteopathic profession and dedication to its growth was evidenced through his influence in the establishment of the Oklahoma State University College of Osteopathic Medicine in 1972. He also counseled hundreds of students who are now osteopathic physicians serving throughout Oklahoma.

Bob is survived by his wife, Gayle Jones; daughter Jennifer and son-in-law Brian Cain of Edmond; daughter Julie and son-in-law Matthew Atyia of Edmond; three grandchildren; and sisters Carol Briggs and husband John of Ripley, Oklahoma; Betty Beal of Kingfisher; and Sherry Martin and husband Jay of Moore.

In Memoriam

1999

Ramon G. Blanco, MD March 5
Neal A. Pickett, Jr., MD March 14
Henry D. Wolfe, MD March 29
Winfred L. Medcalf, MD April 1
Robert P. Dennis, MD April 6
Emil F. Stratton, MD April 7
Carl W. Smith, Jr., MD April 8
George L. Hill, MD April 20
Jim M. Taylor, MD April 28
T. Jeff Williams, MD May 17
Thomas Ross Ahrend, MD May 23
Lawrence E.C. Joers, MD June 5
Hyman J. Drell, ... July 15
Lee Bailey Word, MD July 22
Dave B. Lhevine, MD July 31
Michael Allan Houghton, MD August 16
Webb M. Thompson, Jr., MD August 20
Perry A. Lambird, MD August 25
Nolen L. Armstrong, MD September 12
George R. Randels, MD October 2
George B. Carter, MD October 7
John Robert DeBiase, MD October 17
Theodore Turnbull, MD October 19
Sol Wilner, MD October 31
Malcolm Horne, MD November 3
William Clark Cheek, MD November 11
Bill B. Elrod, MD November 17
Donald E. Johnson, MD November 18
Allen E. Greer, MD November 19
Beverly Colvin Chatham, MD December 2
Norman A. Cotner, MD December 3
Alan Knight Braly, MD December 9
Wilson David Steen, PhD December 12
James Thermon McInnis, MD December 18
Douglas Lyons Polk, MD December 19
Thomas S. Llewellyn, III, MD December 26
John Preston McDaniel, MD December 27
Joe Earle Tyler, MD December 31

2000

Hwan X. Youn, MD January 2
Donald Charles Barney, MD January 4
Charles E. Cook, MD January 13
Lynn H. Harrison, MD January 16
Kenneth C. Hoffman, MD January 17
Richard E. McDowell, MD January 17
Harry L. Deupree, MD February 3

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Jane Phillips Medical Center - Bartlesville

Mercy Health Center - Oklahoma City

Norman Regional Hospital - Norman

Orthopaedic & Reconstructive Research Foundation - Oklahoma City

St. Anthony Hospital - Oklahoma City

Saint Francis Hospital - Tulsa

St. John Medical Center - Tulsa

Stillwater Medical Center - Stillwater

Valley View Hospital - Ada

Integris Baptist Medical Center - Donna Schoenfelder - 405-949-3284

Mar. 2	Cardiology Dept.-TBA	7:00am	1 hour
Mar. 3, 17	Tumor Board	7:00am	1 hour
Mar. 10	Cancer Conference-TBA	7:00am	1 hour
Mar. 13	Medicine Dept.-TBA	7:00am	1 hour
Mar. 17	OB/GYN Dept.- "Assisted Reproduction Technology"	7:00am	1 hour
Mar. 24, 31	Tumor Board	7:00am	1 hour

Mercy Health Center- Debbie Stanilla- 405-752-3806

Mar. 2	"Advance Care Planning: A Process for Improving End-of-Life Care"	12:15pm	1 hour
Mar. 8	NeuroScience Inst. Lecture Series	7:00am	1 hour
Mar. 9	Pediatric Oral & Maxillofacial Conference: "Abnormalties and Surgical Management"	12:15pm	1 hour
Mar. 16	"Evaluations & Management of Vertigo"	12:15pm	1 hour
Mar. 23	"Medicare Fraud & Abuse Laws: I'm From The Government and I'm Here To Help You."	12:15pm	1 hour
Mar. 30	"Acute Coronary Syndromes: A Pharmacological and Interventional Update"	12:15pm	1 hour

Southwest Medical Center - Integris - Jonathan Stotler - 405-636-7087

Mar. 1	"Palliative Care"	12:15pm	1 hour
Mar. 8	"Inpatient/Outpatient Treatment of Deep Vein Thrombosis"	12:15pm	1 hour
Mar. 15	"Hospital Acquired Pneumonia"	12:15pm	1 hour
Mar. 22	"Influenza"	12:15pm	1 hour
Mar. 29	"Rapid Breakthrough Performance Improvement"	12:15pm	1 hour
Mar. 7, 21	Prospective Breast Care Conference	12:15pm	1 hour
Mar. 2,9,16,23,30	Cancer Conference	12:15pm	1 hour

St. John Medical Center - Gail Hilst - 918-744-2875

Mar. 2	"Freestyle Stentless Aortic Valves"	Noon	1 hour
Mar. 7	"Ventricular Arrythmias"	Noon	1 hour
Mar. 9	"Coma"	Noon	1 hour
Mar. 14	"Insulin Administration	Noon	1 hour
Mar. 28	"Case Review"	Noon	1 hour
Mar. 17	"Identifying Pathogenic Autoantibodies"	Noon	1 hour

Valley View Regional Hospital - Belinda Runnells - 580-421-1467

Mar. 9	"Antiplatelet Therapy in Prevention of Stroke and Heart Attack"	Noon	1 hour
Mar. 24	"Update on Management of Allergies"	Noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator, at 405-843-9571.

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SPECIAL

Uniform Credentialing Application – Here at Last!

Michelle Seba, CMSC,
Executive Director, OCVO

"Physicians wishing to apply to an HCO must contact the organization before simply completing the form and sending it in. Certain requirements must often be met to be eligible to apply."

Relief has arrived. The Uniform Credentialing Application is official. After months of development with health care organizations (HCOs) throughout the state, a concensus was reached as to the core credentialing data for Oklahoma.

This uniform application is the result of the passage of House Bill 2578 in May 1998, which called for the Oklahoma State Department of Health to develop a uniform credentialing application that shall be used by hospitals, managed care organizations, and other entities needing credentialing. This form is to be used for both initial applications and the reappointment process.

The State Health Department worked closely with the Oklahoma Centralized Verification Organization (OCVO) and other interested hospital and managed care organizations throughout Oklahoma. The group had the additional task of making sure that the application would conform to the Peer Review Law that was approved in May 1999, and task force attorneys Marty Cain and Michael Joseph assisted the group.

Physicians wishing to apply to an HCO must contact the organization before simply completing the form and sending it in. Certain requirements must often be met to be eligible to apply. Contact with the HCO will help identify those requirements and may head off unnecessary denial of a submitted application.

Each organization will also have supplemental information needed to process an application, as allowed in HB 2578. Such additional information may include privilege request forms, malpractice history, professional references, and other information considered privileged and confidential.

Although the uniform application can be completed and re-used numerous times, physicians must be conscientious that it is kept up to date. An addition or deletion of a hospital membership should be reflected on the next application submitted. As a chronological history is required, terminating a staff membership should result in adding an ending date to the listed hospital with the reason for discontinuance. Do not delete the hospital listing.

It is important that signatures have a current date. Submitting an application that was signed two months ago could be returned for a current signature, as this is attesting to the completeness and correctness of the application as of that date. Joint Commission on Accreditation of Health Care Organizations and National Committee for Quality Assurance both have requirements regarding the currency of signatures, plus an oversight in not updating the application could cause a denial for submitting false information.

Three areas to watch: 1) Section 2, Directory Information – although the form doesn't request it, make a copy of this section and complete it for each office location. This instruction is expected to be on a future version; 2) Section 3, Current Professional Practice — the questions in the middle of the page could possibly change depending on the HCO to which the physician is applying; 3) Section 11, Office Information, covering physicians (near the bottom of the page). It is possible that this information could change depending on where the physician is applying. Each covering physician must be affiliated with that particular HCO also.

And, as the cover letter instructions state, if a field doesn't apply, mark it as not applicable (N/A). This lets the receiving organization know that the item was not an oversight and will avoid an additional phone call or letter to clarify the item. Be sure it is completed legibly!

OCVO populates its applications when sending them to physicians for final completion and is already downloading the new uniform application. OCVO is updating its data base to include the few additional areas on the new form. Physicians may contact OCVO for populated applications at (918) 971-5848.



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PHYSICIANS:

The 2000 Loss Prevention seminars have been scheduled. All OSMA-ERF loss prevention seminars are open to any physician.

Attached is a schedule of Loss Prevention seminars to be conducted by the OSMA-ERF. If you have any questions, you may call Michele Smith at OSMA-ERF CME Planning at 405/843-9571 or 800/522-9452.

For information on Tulsa seminars contact TCMS at 918/743-6184.

Programs are held from 6:00-8:00 p.m. An ***optional*** hour has been included from 8:00-9:00 pm to cover Medical Ethics for all courses except the May 4th Oklahoma City program. The Loss Prevention Committee has mandated that physician's assistants, nurse practitioners, RNs, LPNs, and other employed licensed or certified medical personnel who are insured by PLICO attend a loss prevention seminar.

MEDICAL OFFICE PERSONNEL:

The seminars for medical office personnel have been scheduled in conjunction with the Loss Prevention programs. All programs will be offered from 1:30 p.m. - 3:30 p.m. with the exception of the Oklahoma City programs on March 7 and October 10. Both of those dates will have programs from 9:30 a.m.-11:30 a.m. and again from 1:30 p.m. - 3:30 p.m.

Seminar Registration

Print full name: _____

❍ Doctor ❍ Resident ❍ Other

Office/Clinic Name: _____

Office Address: _____

City/State: _____ zip: _____

Seminar Date & City: _____ time: _____

Mail or fax registration to OSMA Headquarters (attention Michele Smith)
601 W. I-44 Service Road
Oklahoma City, Oklahoma 73118

(405) 842-1834 (fax)

OSMA/PLICO 2000 Loss Prevention *Seminar Schedule*

March

March 7 Oklahoma City Tuesday 6:00-8:00 p.m.
*optional - "Medical Ethics" 8:00-9:00 p.m.
Central OK Home Builders Assn,
625 W. I-44 Service Road

March 14 Ardmore Tuesday 6:00-8:00 p.m.
*optional - "Medical Ethics" 8:00-9:00 p.m.
The Conference Center @ Mercy Memorial
1011 14th Avenue NW, Ardmore

March 16 Muskogee Thursday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Ramada Inn, 800 S. 32nd, Muskogee

March 21 Enid Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Holiday Inn, 2901 S. Van Buren, Enid

March 28 Shawnee Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Shawnee Library Community Room
101 N. Philadelphia & Main, Shawnee

April

April 4 Woodward Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Northwest Inn, Highway 270 South, Woodward

April 5 Guymon Wednesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Ambassadors Inn, Hwy 64 at 21st Street

April 11 Elk City Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Holiday Inn, 101 Meadow Ridge

April 18 McAlester Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Holiday Inn, US Highway 69 Bypass South

April 25 Stillwater Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Best Western, 600 E. McElroy

May

May 4 Oklahoma City Thursday 6:00-8:00 p.m.
Westin Hotel-Downtown, One North Broadway

May 9 Duncan Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Simmons Center-Wildhorse Suite, 800 N. 29th

May 16 Vinita/Miami Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Best Western Restaurant, 2225 Steve Owens Blvd.

May 18 Lawton Thursday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Holiday Inn, 3134 Cache Road

May 23 Ponca City Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.
Holiday Inn, 2215 N. 14th

October

October 10 Oklahoma City Tuesday 6:00-8:00 p.m.
*optional-"Medical Ethics" 8:00-9:00 p.m.

PLICO LOSS PROGRAM OBJECTIVES:

• Familiarize physicians with the most common medical malpractice hazards. • Dispel the belief in certain malpractice myths. • To replace myths with facts that will allow a physician to either avoid a medical malpractice situation or to be more defendable if involved in one. • To identify specific interpersonal relationship problems that can encourage medical malpractice lawsuits. • To recommend specific improvements in the area of doctor-patient communications that will encourage cooperation and reduce misunderstandings.

ETHICS FOR MEDICAL PRACTICE OBJECTIVES:

• Identify possible ethical problems that may exist in their practice. • Recognize how such problems impact patient care and relations. • Subject each situation to four part test to determine its ethical implications. • Apply ethical principles to resovle the situation and improve patient relations and care. Identify new ethical issues as they arise in practice.

Tulsa County Medical Society is sponsoring three (3) Loss Prevention seminars on the following dates:

❑ June 7 ❑ September 6 ❑ November 8

For More Information on the Tulsa Area Seminars
Contact TCMS at 918-743-6184

Busy Agenda Set for OSMAA Convention

Karen A. Pepper Mueller and Diane Brown, Co-chairs, OSMAA Convention

Fun plans are underway for Alliance attendees during the OSMA/OSMAA Annual Meeting, May 4-7 at the Oklahoma City Westin. At noon on Friday, May 5th, plan to attend the OSMA/OSMAA luncheon featuring Dr. Abraham Verghese, professor of medicine at Texas Tech University and author of *My Own Country* and *The Tennis Partner.* A book signing will immediately follow.

On Friday afternoon all Alliance members and their guests are invited to tour the Oklahoma City Symphony Decorators' Showhouse. This mission-style home at 3205 N.W. 19th Street in Linwood Addition was designed by the same architect who designed the State Capitol and the Skirvin Hotel. Members-at-Large will be our special guests for this fun afternoon, which also features "high tea."

Don't forget to attend the silent auction on Friday and Saturday and bid on very creative theme baskets and gifts provided by County Medical Alliances. Money raised from this event will bring in thousands of dollars for the AMA Foundation to provide funds for medical education and research.

On Friday evening, the OSMA/OSMAA Presidents' Reception and Inaugural Banquet will be held at the beautiful Cowboy Hall of Fame honoring incoming OSMAA President Mary Ann Couch and OSMA President Robert J. Weedn, MD. This year's keynote speaker is U.S. Surgeon General David Satcher, MD, Ph.D.

The Alliance House of Delegates meeting at 9:30 a.m. on Saturday morning provides members the opportunity to hear updates from officers and committee chairs on Alliance activities throughout the state. Later that day, join Alliance members and their spouses for a complimentary canal ride and Myriad Gardens tour sponsored by the Physicians' Campaign for a Healthier Oklahoma.

In your "spare time," the Bricktown area of downtown Oklahoma City offers fine dining, sports events, shopping, canal walks, etc. Additional details for all Alliance functions will be highlighted in the April *Sooner Heartbeat.* Plan to attend the Annual Meeting now and fill out the registration form included in this issue of the *Journal.*

We're looking forward to seeing all of you in May!

Alliance Gets New Executive Director

Kathleen A. Musson was recently named Executive Director of the OSMA Alliance. In announcing the appointment, Brian Foy, OSMA Executive Director, said that while the organization has always provided the Alliance with clerical and administrative support, this is the first executive level staff to work directly with the Alliance officers and Board. He went on to say, "This move represents an acknowledgment of the increasingly important role the Alliance plays in furthering the objectives of the OSMA."



Kathleen Musson

Since beginning her career at the OSMA in 1970 as a Legislative Assistant, Ms. Musson has also been Publications Assistant responsible for the OSMA News, Annual Meeting Planner, Director of Operations responsible for the daily activities of the association and, during 1997, served as Acting Executive Director for the OSMA. She has also served as staff liaison for most OSMA Councils and Committees. Ms. Musson is currently Associate Executive Director for OSMA and Director of Governmental Affairs.

"We believe Ms. Musson's background and knowledge of OSMA activities and programs make her the ideal candidate to provide the Alliance and the OSMA opportunities to integrate their activities," Foy said.

THE LAST WORD

Senate Leader Adds Support for Tobacco Settlement Trust Fund

Senate President Pro Tempore Stratton Taylor has added his name to the growing list of elected and appointed state officials who favor putting the tobacco money into a trust fund.

Before the 2000 Legislative session began on February 7, the Claremore Democrat authored draft legislation that ultimately could be used as a vehicle to address the trust fund question.

"I think almost everyone agrees that a substantial share of the tobacco funds should ultimately be deposited in a trust fund," Taylor said. "Before we get caught up in deciding where the money will be spent, it's important to start laying the groundwork for a special savings account for the people of Oklahoma.

"I want to stress that my proposal is just a draft, and I expect it to evolve over time as we talk through the many questions that surround the creation of a trust fund."

Currently, Oklahoma's annual share of its $2.3 billion tobacco settlement is being deposited directly into the state's general revenue account. The state will receive annual payments for the next 25 years.

Taylor said several questions need to be answered before a tobacco trust fund is established. Those include: Who will oversee the fund – the Legislature or a special board? If it is a board, does it operate like a university foundation or a traditional state agency board? Who will appoint board members? What powers will the board possess? How will money from the trust fund be distributed? What programs will be eligible for receiving funds? Should there be a cap on how much any one program area can receive from the trust fund in one calendar year?

Under Taylor's draft proposal, the trust fund would be administered by a seven-member board of directors appointed by a variety of state officials.

"I think it's critical that this be a bipartisan panel with representatives from all four corners of the state," he said. "It's also important to have a number of different appointing authorities so no single person will control how the state invests or spends its tobacco money."



Boyd O. Whitlock, MD, right, OSMA President, talks with Rep. Fred Perry of Tulsa at the State Capitol on February 7, the first day of the 2000 Legislative session. Dr. Whitlock served as Doctor of the Day on the session's opening day.

OSMA Members Volunteer for Doctor of the Day Program

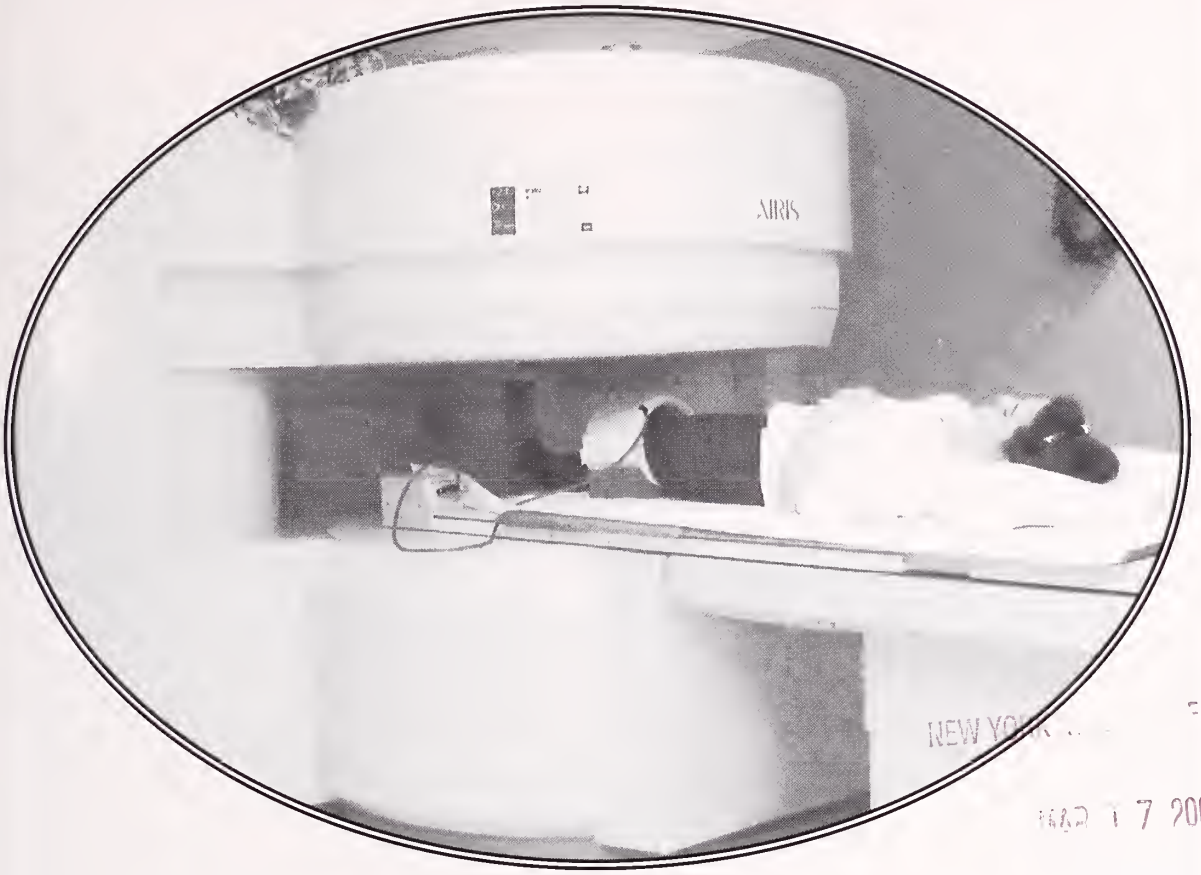
The OSMA is continuing its longstanding practice of sponsoring the "Doctor of the Day" program at the State Capitol when the Legislature is in session. OSMA President Boyd O. Whitlock, MD, served as the session's first Doctor of the Day when the legislature convened on February 7.

Each day of the legislative session, a volunteer serves as the Doctor of the Day. Tulsa County physicians volunteered in February, while Osteopathic physicians will serve in March, Oklahoma County physicians in April, and rural physicians in May.

Correction

Due to a production error in the February 2000 issue of the *Journal*, the acknowledgment listed for "Improving the Health of Oklahomans Through Clinical Prevention Part 1: Counseling to Decrease Major Risk Factors" was incorrect. The acknowledgment should have read: The authors wish to thank the following individuals: Neil Hann, MPH, for his help in accessing and interpreting the BRFSS data; Sue Mallonee, RN, MPH, for her assistance with injury prevention data; and Doug Matheny, MPH, for providing data related to tobacco products. The *Journal* regrets the error.

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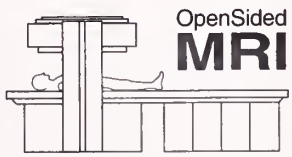
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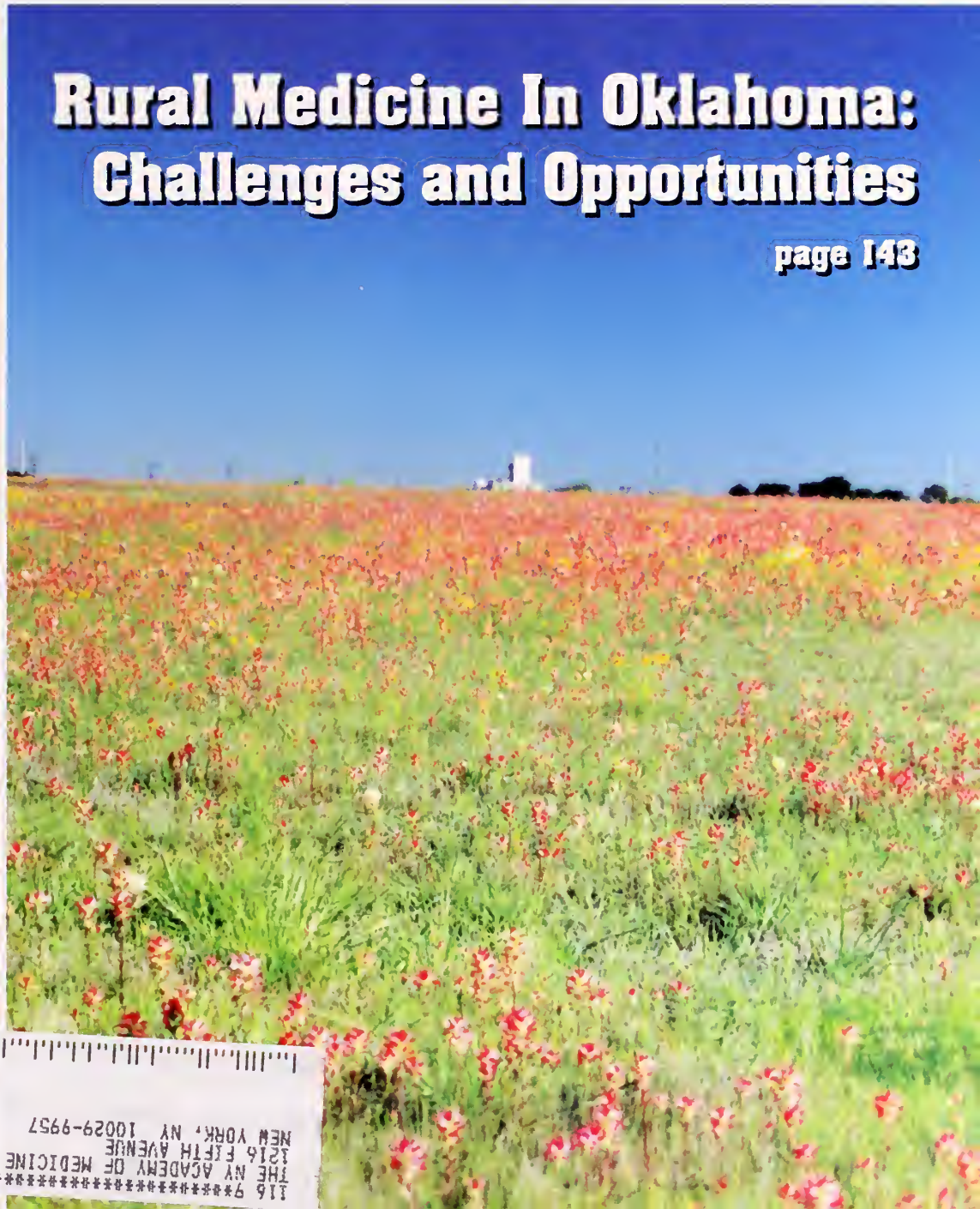
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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

Rural Medicine In Oklahoma: Challenges and Opportunities

page 143



INSIDE:

Scientific
150

State of the State's Health
161

News
169

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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

APRIL 2000 VOL. 93, NO. 4

EDITORIAL
The Wisdom of a Rural Path 139
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE
The Grass Roots 141
BOYD O. WHITLOCK, MD, TULSA

SPECIAL
Physicians Face Challenges in the Practice of Rural Medicine 143
JIM STAFFORD, OKLAHOMA CITY

SPECIAL
Rural Hospitals Provide Much-Needed Patient Care 148
JIM STAFFORD, OKLAHOMA CITY

SCIENTIFIC
Preventing Carpal Tunnel Syndrome and Cumulative Trauma Disorder: Effect of Carpal Tunnel Decompression Exercises: An Oklahoma Experience 150
HOUSHANG SERADGE, MD, OKLAHOMA CITY; CARRIE BAER, OTR, OKLAHOMA CITY; DEFORREST BITHELL, OKLAHOMA CITY

SPECIAL
Preventive Care in Daily Practice 154
R. SUZANNE FERGUSON, DO, OKLAHOMA CITY

SPECIAL
State of the State's Health 161

SPECIAL
State Health Agency Promotes "Safe at Home" for Child Abuse Prevention Month 167
MALINDA REDDISH DOUGLAS, MPH, OKLAHOMA STATE DEPARTMENT OF HEALTH; CAROL GEHUE, OKLAHOMA STATE DEPARTMENT OF HEALTH

NEWS
Resident Award to be Established, 169...Area Physicians Announce Community Service Projects, 169...Zingarelli Appointed Cancer Liaison Physician, 169...Organ Sharing Network Proposes Definition of Imminent Death, 170

DEPARTMENTS
Letters to the Editor, 171...Obituaries, 173...In Memoriam, 173....Classifieds, 174...CME, 175...Alliance, 179...The Last Word, 180

ABOUT THE COVER
Field of Indian Paint Brush taken south of Lawton in the spring of 1999.

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The Wisdom of a Rural Path



I have been there. I have paid the price, spent my time in rural Oklahoma. I fought with Medicare and Medicaid on behalf of our local hospital. I have attempted to make a point that better and more compassionate care was accessible in rural Oklahoma. I told the story to the medical school, I told the story to politicians, I told the story to granting agencies, and I told the story to myself.

Then I left rural Oklahoma.

It was ten years ago that I left. My physician wife and I decided to seek our fortune in other areas of medicine. We made the choice to practice in a larger community, a place with more opportunity for each of us professionally and for our family as they continued their education.

Do I miss rural medicine? Yes, each day I have pangs of guilt for leaving a partner and a community that I had grown to love and respect. Yes, each day I remind myself of how I would have dealt with a clinical situation ten years ago, when I had the opportunity of practicing from my head and heart rather than ordering another test or obtaining another consultation.

Yes, I miss it.

This conversation is extremely foreign to many of you. It does not make a bit of sense. There is no way that you would be caught practicing in rural Oklahoma. There is a bit of professional prejudice in your belief system. If a physician were well trained and skilled, why would he/she waste their career on rural Oklahoma? You would never be so brazen to articulate that prejudice, but it is there nevertheless.

I have often wondered if the rural preceptorships are valuable rotations for medical students. I will point out that they are stuck on the fourth year curriculum, long after most students have made their decision about their lifework. Is that because this is where it naturally fits in the training of a medical student? Or is the difficulty that our academic institutions are worried about protecting the impressionable minds of younger students? Many of us remember walking through the doors of medical school with idealism dripping from every pore. Many of us grew up in rural Oklahoma communities, transiently thought about returning to practice, only to have many distractions thrown in our "medical education" path.

There is a crisis brewing in the state of Oklahoma. The crisis is access to appropriate medical care for the rural citizens of our state. The concerns are centered on a dwindling supply of clinicians willing to attempt this style of practice. The further restriction of Medicare, in the drive to balance the Federal budget, is forcing communities to close hospitals and do away with needed health care services. This belt tightening disproportionately falls to rural communities…communities which also have less opportunity to go after other forms of insured patients.

And then there is the percentage of rural Oklahomans covered by Medicaid with its sustaining funding for rural health care.

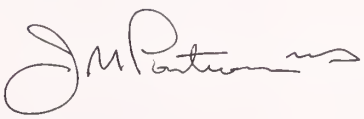
Not!

The problem is complex. There seems to be so many competing agendas, so many bureaucratic systems in place to address components of the problem. The rural practitioner does not have the time or energy to deal with the bigger picture, and the rural legislature does not possess the skills or knowledge to tackle the problem. The Medicare problem is much too great. This is bigger than a local Oklahoma problem. Medicaid is woefully under-funded, and much too worried about the political perception of the client, to spend time concerned about the provider or their institution.

So the "morass" continues.

Patients are being placed at risk because they have to drive an additional 45 miles. Patients are being put at risk because the doctor now works in the next community. Patients are being put at risk because there is no longer a "trickle-down effect" for the survival of rural practices and hospitals.

But that's all right. Anyone who would chose to live in rural Oklahoma must not value access to health care anyway…



J. Michael Pontious, MD
Editor-In-Chief

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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The Grass Roots

The future of "Organized Medicine" lies in the grassroots physicians — in their offices, in their individual practices, and in their local or county medical societies. As the AMA is looking at ways to downsize the national organization and put more control at the state association level, we as a state society need to look at similar measures to organize the county societies. We need to find ways to give each individual physician more input into the decisions made, to give each of them a feeling that they are part of the association, and that their ideas and their problems are important to the planning and the day-to-day decisions that affect all of us.



For the two-thirds of our physicians who live in Tulsa and Oklahoma City, this is an easier task since they are all located in two small localized areas. For the other one-third who are scattered over the state, this will be a more challenging problem. We at the OSMA will need the help of Oklahoma City and Tulsa to make this possible.

Over the past two years, we have begun visiting the county medical societies to inform them of the activities of our association, to educate them regarding our Physicians' Campaign for a Healthier Oklahoma, and, even more importantly, to get better acquainted on a person-to-person basis. We want each physician to know what their association is doing on their behalf and get their input regarding our future. At this point this year, we have visited approximately 15 medical societies and plan to continue these visits into the coming year. We have received positive feedback from several counties, and they have asked us to work with them in areas of public relations/communications and public health. We are scheduling a meeting with all county presidents soon to talk about the OSMA-county relationship and other topics pertinent to all of us. We also plan to begin visiting hospital staffs and some of the large medical groups in order to create a closer relationship with the grassroots physicians. I feel that these activities have been, and will continue to be, beneficial to all concerned.

The OSMA officers and the Board of Trustees are looking at long-range plans for our future. We will be looking at our current structure and possible changes that we might recommend to help accomplish our goals. Several states have already begun to move in this direction. Some state societies are looking at ways to set up regional or branch offices to better provide governance at a more local level. Maryland is consolidating the efforts of the state and 24 component societies to function more as one organization.

Your OSMA will be looking at ways to make the appropriate adjustments that are necessary to meet the changing environment of today's medicine. This effort "to change" will not be easy. Some will feel that thoughts of change are a threat to our customary way of doing things. We are used to doing things in a certain manner, and we are uncomfortable with discussions of changing our S.O.P.

We will all need to work on this together. We need input from all of you. I don't think we can afford to sit still while all around us is changing.

Boyd O. Whitlock MD.

Boyd O. Whitlock, MD
OSMA President

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Physicians Face Challenges in the Practice of Rural Medicine

Jim Stafford

Introduction

Alarm bells have been ringing for years over the state of the health care industry in rural Oklahoma. Rural hospitals are squeezed financially by dwindling revenue streams, and some have closed. In December, Governor Frank Keating said as many as 25 other rural hospitals around the state are in a critical financial situation, much of it the result of a cutback in Medicare and Medicaid reimbursements mandated by Congress. For rural Oklahomans, the crisis translates into questions about access to the health care system – to facilities, technology, and personnel. Of course, it's not only health care consumers who are confronted with such unpleasant possibilities. Hundreds of rural Oklahoma physicians maintain their practices in a landscape marked by a growing web of managed care restrictions, diminishing financial incentives, shrinking pool of colleagues, and worries over the financial stability of local hospitals. So, why don't they move their medical practices to areas where the economics seem to make more sense? In this article, a pair of rural Oklahoma physicians practicing in different parts of the state talk about what brought them to their current practice and why they stay.

Just Passing Through...

Every year thousands of Oklahomans flock to Lake Texoma along the Texas border to relax, play, and soak up the vacation atmosphere offered by the tourist Mecca. For many vacationers, the road to Lake Texoma carries them through the Marshall County community of Madill, which sits only about 10 miles north of the lake.

A bustling town of 3,000, Madill offers a number of restaurants and shops designed to tempt some of those vacationers into stopping for a while. But most are just passing through.

Twenty-one years ago, Joe L. Potter, MD, and his wife Judy thought they were only passing through when Dr. Potter opened his medical practice in Madill.

After completing his internal medicine residency in Oklahoma City, Dr. Potter began his practice in Madill to meet the requirements of a scholarship program that helped him complete medical school.

"We came here with the idea that we wouldn't stay," Dr. Potter recalled recently as he sat in the office of his Texoma Health System clinic, which is located adjacent to Integris Marshall Memorial Hospital in Madill. "They gave us a stipend for the last couple of years of medical school in exchange for four years of service here."

So why is Dr. Potter, 51, still practicing medicine in this southern Oklahoma community two decades later? Certainly, he has faced a number of professional challenges in Madill. In 21 years of practice, he has endured the near collapse of the local hospital and has seen the number of physicians serving the entire county dwindle to as low as two at times. He's witnessed the explosion of medical technology, but much of it is accessible only in the state's metropolitan areas. Or across the border in Texas.

But the Potters never left Madill largely because of the roots they quickly established in the community.

"After we were here about six months, we discovered that we enjoyed the relationship with the people, we enjoyed our church, and we enjoyed the small-town living," he said. "Those roots just kept going deeper and deeper, I guess."



Joe Potter, MD, opened his practice in Madill 21 years ago. He is one of four physicians in the area.



Community support for Marshall Memorial Hospital had enabled Dr. Potter to remain in Madill.

So deep that they raised their daughter in Madill. So deep that Dr. Potter became a deacon at the First Baptist Church, where he also serves as a lay preacher. So deep that Dr. Potter served on the school board for 11 years.

"It's quiet. It's still a reasonably safe community as far as not a lot of crime and stuff going on. And it's fast-paced enough for my blood," he said with a laugh.

Although Judy Potter is a native of Bethany, Dr. Potter was familiar with the Marshall County area when they arrived in 1978. He was raised in Denison, Texas, just across the border, and later, Durant, about 30 miles to the east of Madill.

Despite all the qualities of rural life that have made Madill home to the Potters, there are certain professional sacrifices Dr. Potter has made in keeping his practice in the rural location for more than two decades.

"Well, the big thing you sacrifice in a small community is the association with colleagues on a day-to-day basis," he said. "Sometimes you are out here on an island. Even though we have four physicians in town and I'm fortunate to have a good partner right now...You miss the ready availability of a specialist, being able to go across the hall or meet in the hospital and say 'would you mind looking in on Mr. Smith and see what you think about his situation?'"

Then there's the issue of technology. Patients today expect routine access to MRI or other technology that medicine has embraced.

"When I first got here it was actually a little easier because the technology explosion was beginning to happen at that time, but it was not as much expected as it is today," he said. "You have to fight the battles of proving that you don't have to have an MRI in the next room to practice good medicine. But on the other hand, those patients expect the state-of-the-art medicine to be practiced."

So, are Potter and his Marshall County colleagues practicing state-of-the-art medicine since not every technological advance is readily available?

"Yeah, we are," he said. "But we can't do it locally. We do have the availability in Ardmore and in Denison. We have cardiovascular surgeons available to us, we have neurosurgeons, we have the latest equipment available, but our patients have to travel. It's a little more inconvenient."

If there was a time when Dr. Potter considered closing up his clinic and relocating to an area with more professional promise, it was in 1992 when Marshall Memorial Hospital was on the verge of closing because of financial difficulties.

"We had lost all the doctors except myself and another physician in town, so we were down to two doctors," he recalled. "That was a time in my life where I thought 'is this worth staying on or not?'"

"Fortunately, at that time is when the community really knew the importance of the hospital and got behind us."

Marshall County residents passed a 1-cent sales tax that kept the hospital operating. Then they took things a step further. A group of local residents raised more than $250,000 that was used to recruit two new physicians to the community.

"Things kind of turned around for us," Potter said. "If the hospital weren't here I wouldn't be."

Today, the Madill hospital operates under a lease agreement with Oklahoma City-based Integris Health System, which provides another measure of stability for the community, he said.

As for community support, local residents recently voted to extend the 1-cent sales tax for another 10 years to finance major renovations of the hospital, which was built in the 1960s.

Dr. Potter said the practice of rural medicine —clinicians and hospitals alike—is most affected by the financial limitations imposed on health care providers by the Medicare and Medicaid programs. The biggest percentage of his insured patients are those enrolled in the federal programs.

"We really take a hit on Medicaid," he said. "The reimbursement is horrible. If you have a practice full of Medicaid patients, you're not going to survive very long, and a hospital won't survive on Medicaid."

Rural hospitals and practitioners face even more Medicaid limitations than their urban counterparts, he said.

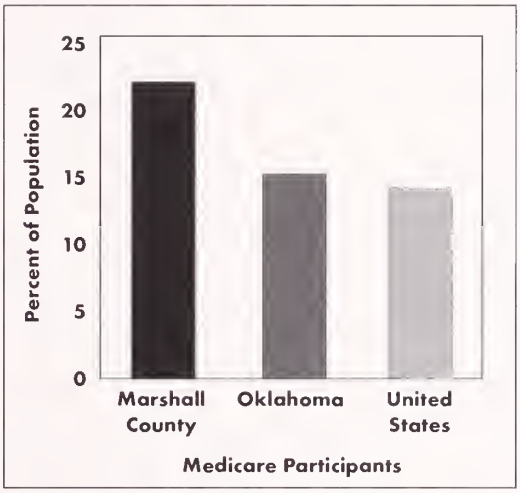
"There's a formula the federal government uses that has to do with locations, the size of the hospital, case mix. All that figures into the formula, and rural hospitals are way down on the bottom of the formula. It's not a fair system."

In 1996, Dr. Potter took a big step to ensure the stability of his practice by selling it to Denison-based Texoma Health Care Systems. The system comprises 42 physicians in five counties on both sides of the Red River.

"Now I'm an employed physician," he said. "The advantages of that are several: I don't have to do the day-to-day business part of the practice any more; I don't have to manage personnel full time; there is availability of colleagues interacting. It's helped us tremendously in giving us managed care contracts and managing the managed care aspect of a physician's practice that I didn't have before. In a rural area, that's quite a bit of security for me."



Dr. Potter cites the small-town lifestyle—including his relationship with the people of Madill—as one reason he has remained in the area.



One reality of rural medicine that continues to plague the Marshall County community is the shortage of physicians. After this interview was completed in early January, Dr. Potter learned that one of the four local physicians was retiring, setting off yet another crisis. The community already was working to recruit two new physicians to the area. Now it will have to add to its efforts.



Kyle Waugh, MD, practices family medicine at the Weatherford Clinic.

"One thing about rural medicine is that the loss of one doctor can reduce the work force by 25 percent and increase the work load by 100 percent," Dr. Potter said.

Programs such as the Physician Manpower Training Commission help bring new physicians to rural Oklahoma, but the success is limited by the numbers of medical students who opt for a specialty that isn't compatible with rural practice, he said.

"They may come out as a neurologist who certainly is not going to set up in Madill or rural Oklahoma," Dr. Potter said. "But for those students and those physicians who continue in primary care areas of medicine, they can end up in a small community."

But there are other barriers to recruiting young physicians to rural Oklahoma, as well. A lot of it has to do with technology, Dr. Potter said. That's evident in the reaction of fourth-year medical students to rural medicine when they arrive at his office on a preceptorship, he said.

"They will come down here to Madill or they will go to Sayre or go to Miami or somewhere, and they spend some time in your offices and they look around and say, 'hmmm, I don't think I want to do this,'" he said. "I think it's in the training and the technology of medicine now. They come out here and think, 'I'm out here naked.' Facilities mean a tremendous amount."

A Lifestyle Choice

Not every young doctor turns and runs after exposure to rural medicine. Kyle Waugh, MD, has practiced in the Custer County city of Weatherford for more than three years, and he says he has no plans of leaving.

Although the family practitioner was recruited to this western Oklahoma community of 10,000 while completing his residency, he said he planned all along to practice in a rural area, specifically western Oklahoma.

"Rural for lifestyle reasons and for practice style," said the 32-year-old graduate of the University of Oklahoma School of Medicine. "I wanted to do a broad range of family practice, which means I wanted to do my obstetrics and to do the procedures that I enjoy. That's almost expected in a rural area, but excluded in an urban area."

Dr. Waugh claims legitimate rural roots. He was born in the Texas panhandle and was raised in a small Colorado community. He said Weatherford is a good fit for his practice needs.

Situated along I-40 and surrounded by wheat fields, Weatherford offers some things that are unique among western Oklahoma communities. It is home to a college—Southwestern Oklahoma State University —and some manufacturing.

"I don't consider Weatherford to be a small town, but I still consider it to be rural," Dr. Waugh said. "I liked Weatherford because, first, for a rural area it's fairly young and not entirely geriatric. With the Imation (computer disks) plant, it had a lot of professionals here. And it had good doctors with a decent call schedule."

Dr. Waugh practices with five other doctors at the Weatherford Clinic. Although tied together in name, each doctor operates his practice independently within the clinic. It's a style of business that gives doctors a certain independence, but costs them on the bottom line, he said.

"I have all my own staff; I do all my own billing, do my own payroll," he said. "I like having control, but I think that's part of the reason that I'm sacrificing financially, because it's not economically feasible—very redundant—to have six different doctors in this building and six different office managers and six different people doing transcriptions and six different receptionists."

A Physician Manpower Training Commission grant helped Dr. Waugh set up his Weatherford

practice, but he said the financial aid, which totaled approximately $40,000, didn't go far when all the costs of starting his business were factored in. Plus, he's still paying down the debt of medical school, which is far higher than average because he paid out-of-state tuition.

It's such a financial burden that he can't help but compare the cost of maintaining the rural practice against the earnings potential offered in an urban setting.

"My student loan debt is in the top 96 percentile, and, yet, last year I made one-half the national average for my specialty," Dr. Waugh said. "So, why am I still here?"

There's a long pause as he contemplates his own question.

"I like it. I do like it. I like living in a rural area, and I don't know how to explain that," he said. "I guess there's just some people who are country folk, and I'm a country folk. The things I like to do are in a rural area. I like hunting and fishing and outdoors kind of stuff, and this is where I'm at. I like the people and the work ethic of the people, and the friendliness of the people."

Meanwhile, 185 miles or so to the southeast of Weatherford, Dr. Potter sits at his desk and ponders whether he would still be in Madill if he had to do it all over again.

"That's a good question," he said, laughing at the thought. "If I went back in the same setting 21 years ago, I wouldn't have any problems staying at all. In today's setting, I would probably look at rural areas, but would be more inclined to probably go to a middle-sized town than a town the size of Madill. That's no reflection on Madill or rural areas. It's just knowing what I know about the trials and tribulations of rural medicine, coming out as a new physician, I may look elsewhere."



Dr. Waugh enjoys the combination of rural and urban provided by the western Oklahoma community of Weatherford.

SPECIAL

Rural Hospitals Provide Much-Needed Patient Care

Jim Stafford

What's ailing Oklahoma's rural hospitals? What has caused a financial crisis of such proportions that Governor Frank Keating in December said as many as 25 of the state's rural hospitals may shut down?

Norma Howard, Integris Marshall Memorial Hospital administrator in Madill, sums it up in one word for her health care operation: Medicaid.

Why? The federal program pays rural hospitals 15 cents for every $1 of service they provide their patients, Howard said.

"When those patients step in our door, we can't say 'you can't come here,' but you hate to see a patient when you know that if you charge $100 you are going to get $15," Howard said in a recent interview.

Medicaid is a jointly funded, federal-state health insurance program for certain low-income and needy people. It covers approximately 36 million individuals nationwide including children, the aged, blind and/or disabled, and people who are eligible to receive federally assisted income maintenance payments.

In Oklahoma, approximately 9.5% of the population is covered by Medicaid, 17% lower than the national total of 11.4%, according to statistics included in the 2000 State of the State's Health Report released in February.

But in Marshall County, about 12.5% of the 12,752 residents are enrolled in the Medicaid program, which is 32% higher than the state average. Howard said approximately 10% of her hospital's admissions in 1999 were covered by Medicaid.

Medicare pays a better percentage to health care providers, approximately 50 to 60 cents for every $1 of service provided, Howard said. Medicare provides health insurance coverage for people over age 65 and for people with certain disabilities.

Howard said about 70% of her hospital's admissions in 1999 were covered by Medicare. Nearly 23% of Marshall County residents are covered by Medicare, which is 51% higher than the state average.

Howard said the Marshall County hospital benefits from a 1-cent county-wide sales tax that voters approved in 1992 to help it meet operational expenses. Plus, Marshall County is home to the booming tourist industry generated by nearby Lake Texoma, which broadens its patient base beyond Medicare and Medicaid, she said. Those are advantages not enjoyed by many rural Oklahoma communities.

"Some communities are just farming communities; they have no industry," Howard said. "They have no insurance populations. There's nothing there. They have Medicare; they have Medicaid."

But there have been tough times for the Marshall County hospital, as well. The county-wide sales tax was passed in response to a major financial crisis when it appeared the county-owned acute-care hospital would be forced to close in 1992 because of financial losses. The decisive action by county residents changed the bleak outlook.

"I think what's neat about this community is that when we did have that crisis, the 1-cent sales tax was to help bail out the hospital from the operational situation it had gotten itself into at the time," Howard said. "Then the community got together and created a $250,000 physician recruitment fund. It was over and above the sales tax, and it brought two physicians to our community and got us going."

Had the hospital closed in 1992, physicians already practicing in Madill likely would have relocated to other communities. And there were only two at the time.

Joe L. Potter, MD, has practiced in Madill for 21 years, but he said the 1992 financial crisis made him consider alternatives. He said he wouldn't be there today without the presence of the hospital.

"A hospital is a necessity for our community and our practice," he said.

Dr. Potter said the hospital remains strong in part because outside management took over its operations after the 1992 financial crisis. First, Howard took over as administrator.

"Norma was not here when the problems started, but she was a big part of the solution to our problems," Potter said.

Then Baptist HealthCare of Oklahoma assumed operations with Howard remaining as administrator. Baptist HealthCare later merged its 13-hospital network with Baptist Medical Center of Oklahoma City, and the company eventually changed its name to Integris Health.

Howard said Integris Marshall Memorial Hospital's patient demographics have improved in the eight years since its financial crisis. In 1992, about 90% of its patients were covered by Medicare and the other 10% by Medicaid, she said.

Integris Marshall Memorial Hospital also has taken steps to narrow the scope of its business, Howard said. The hospital has shed unneeded services—it closed its surgery room, for instance—and downsized from the 50-bed facility for which it is licensed.

"The most patients we've had in the last two or three years was 25," Howard said.

Local citizens recently voted to extend the sales tax for 10 more years, which will finance a much-needed facelift for the hospital. Remodeling plans are underway, awaiting only state approval, she said.

Howard remains upbeat about the hospital's future.

"I see our situation improving a great deal, but it's because of the community in which we live," she said. "It's not a farming community. We have a huge resort, retirement community down on the lake. People come in from Oklahoma City and Dallas, and those people are not necessarily Medicare. These are people who come down here to retire and most of them have insurance."

"Also, we have something that very few communities have and that is industry. Marshall County has between 1,500 and 2,000 industrial jobs, and every one of those employees is insured. Marshall County has a very good outlook compared to some communities." J



Norma Howord, hospitol odministrotor, maintoins o positive outlook on the future of the focility.



Integris Morsholl Memoriol Hospitol neorly closed in 1992, but residents opproved o 1-cent soles tox to help the focility meet its operoting expenses.



Dr. Potter's medicol proctice in Modill would likely hove closed if the hospitol hod closed its doors. "A hospitol is o necessity for our community ond our proctice," soys Dr. Potter.

SCIENTIFIC

Preventing Carpal Tunnel Syndrome and Cumulative Trauma Disorder: Effect of Carpal Tunnel Decompression Excercises: An Oklahoma Experience

Houshang Seradge, MD; Carrie Bear, OTR; DeForrest Bithell

This work supported in part by a grant from the Orthopaedic & Reconstructive Research Foundation.

An Oklahama meat packing campany with 286 praductian warkers experienced a high incidence af cumulative trauma disarder (CTD), specifically carpal tunnel syndrome (CTS). The campany learned abaut the Carpal Tunnel Decampressian Exercises (exercise program) thraugh the American Academy af Orthapedic Surgeans' afficial web page. The Orthopaedic & Recanstructive Center assisted the campany with implementatian af the exercise pragram. The company reparted their ane-year fallaw up findings ta the Gavernar's Cauncil an Safety Policy (State af Oklahama). The exercise pragram was the anly erganamic change the campany implemented that year. The campany's workers' compensation lass ratia impraved from 13.89% to 11.61%. The campany reported a net financial gain after camparing injury reductian versus work time lost to exercise. The incidence of Cumulative Trauma Disorder, excluding Carpal Tunnel Syndrome, was reduced 37% and Carpal Tunnel Syndrame was reduced 45.4%. The results af the exercise pragram were significant enaugh that the campany made the exercise pragram permanent.

Introduction

Cumulative trauma disorder[1-3] (CTD) is one of the most serious safety issues facing workers[4] and employers today. This condition is also known as repetitive trauma disorder,[3] repetitive stress injuries,[5-7] overuse injuries,[5-7] repetitive strain injuries,[8,9] and repetitive motion disorders.[10] These disorders encompass many conditions involving the upper limbs, shoulders, and neck and are a major public health problem[11,12] causing significant pain and functional impairment.[11] It is predicted that 50% of the American workforce will experience[9] CTD by the year 2000 (Figure 1) costing more than 1 trillion dollars.[1]

Carpal tunnel syndrome (CTS), the most common of cumulative trauma disorders,[13] is called the disease of the century.[14] It has an incidence rate as high as 14.8% in certain high-risk occupations.[14,15] Industries reporting the highest incidence rates are those involving manual handling and repetitive tasks, the highest of which are food-processing companies.[16] Specifically there is a high incidence of CTDs in the meat packing industry due to the repetitious and hand-intensive work involved.[12,17] Masear[14] documented the devastating economical effects of CTS leading to the closure of factories.

In the past, the focus has been centered on the treatment of these disorders through ergonomic changes. While some improvements have been achieved,[9] the incidence still remains on the rise.[4] Until research can provide specific dose and exposure relationships for the individual, prevention remains the best treatment for CTS and other CTDs in the workplace.[12]

The role of performing warm-up exercises prior to physical activities and athletic engagements is well known for reducing and preventing injury. The senior author presented his CTS research conducted in Oklahoma to the American Academy of Orthopaedic Surgeons (AAOS) in 1996.[18] The AAOS has included the Carpal

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Tunnel Decompression Exercise Program (exercise program), which was developed from this research, as a recommendation for the prevention and treatment of CTS. The exercises have been posted on the official AAOS World Wide Web page[19] since 1996 as "Exercises to Prevent Injuries." The University of Oklahoma Health Sciences Center and many national and international organizations recommend the exercises to their employees for injury prevention. This is the first study evaluating the effectiveness of exercise for preventing injuries in workers.

Background

Seradge et al[20] found that certain activities of the hand and wrist decrease the pressure inside the carpal tunnel for 15 minutes of continuous measurement. This explains the relief of carpal tunnel symptoms as a result of shaking the hand or making repeated fists when patients awake at night from nocturnal paresthesia. Hansford[21] documented that exercise increases blood flow to the wrist and hand; theoretically, improving nutrition and oxygenation of the nerve. Wright[22] and associates reported that median nerve excursion at the wrist is achieved with certain hand and wrist motions. Moreover, they demonstrated the nerve excursion is much more pronounced when multiple upper extremity joints are moved concurrently.

Matias[23] reported that slumped over shoulder posture contributes to CTS, as it is associated with cervical-brachial strain and compression of the brachial plexus. Furthermore, it is documented that poor posture is a contributing factor for other nerve entrapment disorders.[23] Many studies have shown people with poor physical condition are considered high risk for CTS[24-26] and many other CTDs.[24]

Seradge developed the Carpal Tunnel Decompression Exercise Program from review of the CTS literature base and clinical observations.[18,20] The exercises utilize nerve gliding techniques for the cervical, brachial, and peripheral nerves, as well as isometric and isotonic contractions executed to the person's tolerance.[27] The Carpal Tunnel Decompression Exercise Program encompasses 13 specific movements choreographed into an exercise regimen. The exercise program has been donated to the Orthopaedic & Reconstructive Research Foundation, an Oklahoma charitable foundation engaged in medical research and community education.

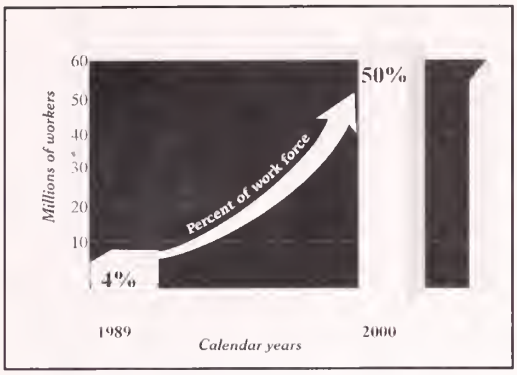


Figure 1: Percent of work force estimated to experience a CTD by the year 2000

Study Design

An Oklahoma meat packing company experienced a high incidence of CTS and related CTDs. The company learned about the Carpal Tunnel Decompression Exercises through the official World Wide Web page of the AAOS.[19] The company then contacted the Orthopaedic & Reconstructive Research Foundation requesting assistance in decreasing the incidence of CTDs, specifically CTS, in their plant. During 1997, their occurrence rate was 14% for CTDs (excluding CTS) and 19.2% for CTS. The senior author provided a hands-on seminar to the management and employees of the meat packing company. As a result of the educational intervention, management and employees collaborated to accept the Carpal Tunnel Decompression Exercises, on a mandatory basis, for all 286 production workers.

The seminar was the only role the investigators played with this company. The investigators were not company physicians; therefore, they did not diagnose or treat any employee of this company, and no financial compensation was received at any point for seminars and/or helping the company to implement the program.

Participation in the exercise program was mandatory and was performed prior to starting production on the assembly line. The exercise started after the workers reported for work and clocked in. No other modifications or ergonomic changes were implemented during that year. The time required for performing the exercise program was 3 minutes and 10 seconds. All production employees were required to perform the exercise program. The workers age ranged from 18 to 64 years with an average of 33.4 years. There were 42% female and 58% male production workers.

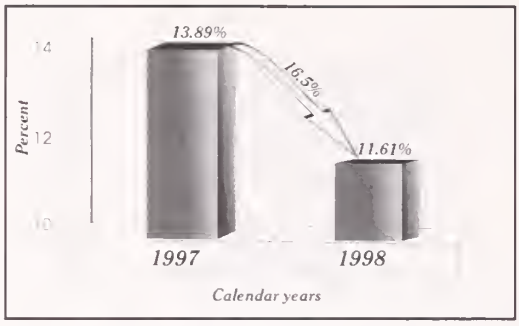


Figure 2: Effect of the Carpal Tunnel Decompression exercise program on the Workers' Compensation loss ratio

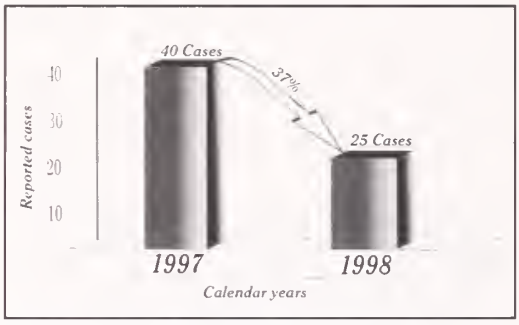


Figure 3: Effect of the Carpal Tunnel Decompression exercise program on the incidence of CTD

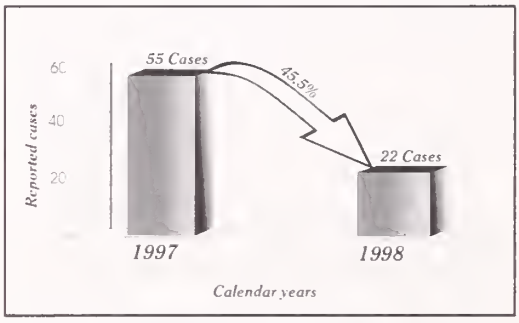


Figure 4: Effect of the Carpal Tunnel Decompression exercise program on the incidence of CTS

Results

The meat packing company's official report to the Governor's Council for the State of Oklahoma one year after implementation of the Carpal Tunnel Decompression exercise program documented a significant improvement in the workers' compensation loss ratio. The workers' compensation loss ratio improved from 13.89% in 1997 to 11.61% as a result of implementing the exercise program (Figure 2). After comparing the cost savings from injury reduction to lost productivity while the employees performed the exercise program, the company reported a net financial gain. In addition, they noted an improvement in both work productivity and employee morale.

The incidence of CTDs, excluding CTS, was reduced from 40 cases in 1997 to 25 cases in 1998, which is a reduction of 37% (Figure 3). Most significantly, the incidence of CTS was reduced from 55 cases in 1997 to 22 cases in 1998, a notable 45.4% reduction (Figure 4).

Discussion

Despite significant ergonomic advances,[9] the rate of reported CTDs is on the rise.[1] It is clear that other interventions are needed. The useful effect of stretching and gentle contraction of muscles prior to athletic activities is well known and mandatory for professional athletes.[5] Most sporting events consist of less than 90 minutes of highly repetitious activities; however, the pregame warm-up may take as much time as the event or activity itself.

One concern that must be contemplated involves why the same pre-activity warm-up is not considered for workers, who are expected to do repetitious activities for 8 hour shifts. Often these workers are in poor physical condition, smoke, are overweight, and are expected to perform strenuous activity without the benefit of stretching or warm up. These workers are prime candidates for injury.[22,24-26,28] The exercise program was designed as an adjunct to conservative treatment of CTS and has yielded significant benefits. The use of Carpal Tunnel Decompression exercise program as a preventative tool is suggested by the AAOS on its official World Wide Web page.[19] Previously there has not been a study regarding the effect of exercise in a group of workers over a one-year period. This research reports that the Carpal Tunnel Decompression exercise program is effective in reducing the incidence of cumulative trauma disorders and carpal tunnel syndrome, when participation is mandatory by agreement between workers and management. As a result, both the employer and the employee realize fewer injuries, cost savings, and improved morale.

Conclusion

The Carpal Tunnel Decompression exercise program is recommended for any worker who performs tasks involving the upper extremities including the neck and shoulder regions. The authors believe that acceptance of the Carpal

Tunnel Decompression exercise program, on a company-wide scale, will only be effective if it is mandatory by agreement. One year after implementing the Carpal Tunnel Decompression exercise program, the result was significant enough that the company has made the program permanent and continues to implement it in the work place.

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SPECIAL

Preventive Care in Daily Practice

R. Suzanne Ferguson, DO

Advances in medical science have led to effective preventive steps that can be used by all physicians; however, most current preventive evaluations and applications are given in primary care settings. Hence, integrating preventive care into practice has become an important challenge for all primary care physicians. This article reviews the delivery of clinical prevention including implementation, barriers, and management. It is clear that preventive care leads to healthier people and that should be the goal of all medicine.

Introduction

In the 1920s there were no immunizations and little treatment was available for most diseases. Hence, prevention of illness was key. Our ability to prevent disease blossomed as immunizations and scientific knowledge about illness became available. One of the greatest strengths in medicine today is the ability to prevent illness through advances in public health and treatment of disease. Disease prevention has many foci today, but the main focus must be prevention and early detection of heart disease and cancer.

Integrating preventive care into practice is an important challenge for primary care physicians. Current preventive screening examinations and guidance are given in primary care settings. The concept of the "complete annual physical" has been replaced with selective health maintenance and direction on items such as smoking cessation. Although most practitioners are familiar with recommended preventive guidelines, the recommendations are not being offered routinely to patients. Practitioners cite several barriers to compliance including reimbursement, time, and forgetfulness. This paper will explore the delivery of clinical preventive medicine, its implementation, barriers, management, and directions for the future.

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Guidelines

The U.S. Preventive Services Task Force Guide was first published in 1989. It set forth preventive services guidelines and emphasized quality improvement. This led to the development of a different health care environment that may have contributed to a trend in preventive screening and intervention. It is well recognized that primary care practices fall well below recommended levels in delivery of clinical preventive services.

In the era of the "annual physical," it usually meant a basic physical exam and potentially a screening test or lab. As the annual physical faded, preventive tools multiplied quickly and were incorporated into clinical visits, as deemed necessary by the physician. Soon, physicians aimed to better organize information using lists and flow sheets in the charts to keep up with screening items due, medications taken, and diagnoses made. The ability to screen for risk factors and diseases has continued to grow. While some physicians have now gravitated to more sophisticated and complex flow charts, others continue to rely on memory and past records; still others are innovators and are computerizing their preventive care, along with other aspects of the medical record. How prevention is being delivered has been the focus of many studies to determine advantages and disadvantages of various methods, cost effectiveness, and quality of care.

Review of Methods

Intervention types, including computerized tracking and a manual flow chart, have been well studied in recent years. Computerized tracking has become popular due to global criteria that are easily seen; reminders to patients are quickly generated and prevention is institu-

tionalized and less dependent on physician motivation and memory. The weaknesses, however, of computerized tracking include significant costs to maintain and operate including more rigid data entry requirements that are not easily individualized to the patients.[1]

In contrast, manual flow charts offer flexibility and are individualized to the patient's needs. Flow charts are inexpensive and technically simple. Unfortunately, as these flow charts are dependent on physician motivation, global changes are not easily made, and a chart audit is necessary to evaluate quality assurance.[1]

Computerized information systems have made a positive impact in health care in administration, finance, and education, yet their potential to facilitate and improve clinical outcomes has barely been tapped.[1] Health care plans vary widely in their use of information systems for collecting and delivering data. In many plans, physicians remain unequipped with computerized patient information resulting in auditors being forced to collect health care data from paper records. One use of the information obtained is the ability to track standard quality-of-care indicators. Some plans have highly integrated systems that collect and deliver data on the health conditions of plan members. Quality-minded consumers measure quality by immunization coverage, cholesterol screening, mammography, early cervical cancer screening, and early prenatal care. Plans look to their information systems to monitor performance on these measures. Plans may send reminders to physicians and patients when screening tests are due, and provide follow up clinical cues if patients fail to respond.[1] There are multiple reasons many involved in health care are increasingly focusing on the technology of computerized information to improve the delivery of preventive care.

Several studies have evaluated clinician-oriented and patient-oriented reminder models to increase compliance with preventive health screening. Yarnall et al[2] show high initial physician compliance rates during the first five months of using a computer-based tracking method. In the study, the physicians checked a box on a page if he or she addressed a particular issue. The form was to be a reminder to address particular preventive issues. Compliance subsequently dropped during the next five months and was not responsive to periodic "pep talks" and training sessions given to clinicians. The screening leveled off around the 14th month of the study with compliance rates ranging from 48 to 65% depending on the counseling item evaluated. Physicians were surveyed 18 months into the study to ascertain their perceptions of barriers encountered to providing counseling for recommended screening. The major reasons for not completing the forms were limited clinician time and the burden of additional paperwork. While the forms took most physicians less than five minutes to complete, counseling and performing the screening tests took 50% of the physicians 10 to 14 minutes and the other half took greater than 15 minutes to complete the work. For most physicians, this is greater than or equal to the time allotted at a given visit to address the patient's presenting complaint. The data suggest that even with the best prompting devices, physicians use the prompts only 50% of the time and the needed health maintenance is completed in less than half of the office visits.[2]

Williams et al[3] published results of a study in which a patient-initiated, touch sensitive computer system was used for improving screening rates for cancers of the breast, cervix, colon and rectum, and oral cavity. This study was an attempt at an integrated systematic approach designed to involve the patient as well as the physician in preventive screening. The study involved the use of a full-time research nurse acting as a liaison to assist patients and staff. Results showed a favorable increase in screening mammography and clinical breast exams, especially for patients who scheduled a health maintenance examination to review preventive health items. This study was, in part, based on evidence that clinicians provide more preventive services to patients who have health maintenance examinations than those patients who seek care only during illness. Patients who had a health maintenance examination during the study year were significantly more likely to have completed all of the screening tests, even after taking into account the effect of the computer system intervention. One drawback of the intervention is the expense of an additional full-time employee needed for the screening program.[3]

Dexter et al[4] evaluated the impact of computer-generated reminders on physician compliance with practice guidelines. Documentation of attempt at discussion of advance directives is currently required for many patients. An established computer-based medical record system was used to generate physician reminders that recommended discussion of advance directives, compared with no physician reminders. The results of this computer-generated reminder

study revealed that physicians who received reminders discussed advance directives with 24% of their patients. Physicians who did not receive reminders discussed advance directives with only 4% their patients.

Overall, 45% of patients with whom advance directives were discussed completed an advance directive. Researchers viewed this method using printed reminders as simple, unobtrusive, and very effective compared with the intensive and expensive support intervention often given in intensive care units. It was emphasized that a computerized medical system was a must for these reminders if quality of care was to be improved while controlling costs. Otherwise, targeting selected patients would be time intensive and prone to error. Other studies examining advance directives have shown that while both patient and physician believe it is an important item to be discussed, each believes the other should initiate the discussion.[4]

Morgan et al[5] evaluated the effectiveness of computer-based reminders in improving compliance with preventive medicine screening guidelines and examined the long-term impact of these prompts. The computerized medical record contained a health maintenance report based on current guidelines and tailored to individual patients. The items appropriate for a given patient are either shown as due or the current result for the exam is shown. This information is available on-line to the clinician at any time and a paper copy can be printed just prior to the patient's visit. This study evaluated the computerized reminder system for more than five years to determine changes in long-term compliance. The end result was that improved performance persisted for seven out of 10 items that showed initial improvement. An observed drop in compliance for three guidelines was an important finding suggesting that for some reminders, the effects wear off over time.[5]

Still other studies explore the extent to which physician characteristics affect the level of care and implementation of guidelines for patients with diabetes mellitus. Most diabetes-related health care expenses occur as in-hospital costs for complications of the disease. There are numerous preventive measures that have been shown to be effective in limiting the number or severity of diabetes complications. Streja et al[6] focused on physician perceptions and characteristics toward preventive screening in this disease population. It found that physicians overestimate the rate at which they make recommended referrals or perform tests. Half the physicians studied thought that they implemented each variable at a rate greater than 90%. In reality, this happened only occasionally.

The most predictive characteristic of physician compliance with the outcome measures was the physician's practice style. Those seeing a high number of patients per unit time had a lower compliance rate as well as a higher morbidity and mortality in their practice. They were further characterized as having a less participatory decision-making style and involving their patients less in the health care process. Finally, this study showed that physicians who see patients in high volume do comply much better when utilizing computer reminders. This method was shown to improve the quality of health care without increasing the amount of time spent with the patient and improved the compliance rate while allowing them to continue to practice in the way in which they were accustomed, without the additional barrier of attempting to further change physician practice habits.

Mandelblatt and Yarbroff[7] reported on a meta analysis performed to review provider-targeted interventions designed to increase the use of mammography. The study was especially interested in determining the most effective strategies for increasing mammography use. In this meta analysis, 21 studies were reviewed and interventions were classified as behavioral, cognitive, or sociological. Cognitive strategies provided information, education, and clarified misperceptions. Behavioral interventions focused on behaviors and reminder systems. Sociological interventions used social norms or peers to increase screening.

Interventions were also designed to target different groups such as providers, patients, or communities. Some studies used multiple interventions and others were more targeted. In all cases, using any type of intervention was found more effective in increasing mammography than control groups that used no form of intervention. Interestingly, strategies targeting physicians only were concluded to be just as effective as strategies targeting both physicians and patients. This was also true for interventions using a single approach as compared with multiple approaches. A lack of synergy was found between any two effective single approaches.[7]

Discussion

Various interventions and implementation strategies have all shown benefits in improving preventive health screening in primary care practices. Most commonly, the studies found that

once the interventions or studies ceased, screening rates again declined. Some studies attempted to impart durability into the program or to institutionalize the screenings. If achieved, a higher level of success is recognized. Durability is the maintenance of some degree of activity continuing even after the original research has ended. Institutionalization is the maintenance of very specific intervention activities.

In review of these studies, preventive medicine is important to many groups with an interest in health care including physicians, patients, insurers, consumers of health care plans, and the United States health care system. Each group has a unique but overlapping interest in decreasing morbidity through preventive care. The delivery of prevention in primary care is important because most preventive health screenings are done in primary care. Most physician practices fall below recommended preventive screening levels. Health maintenance compliance should ideally be 90% to 100%, not the current 50% 80% suggested by the research.[8] Consumers measure quality of care by preventive care compliance rates, making preventive screening a yardstick for evaluation and comparison.

The implementation of preventive care is made more difficult by the barriers that prevent 100% compliance to screening programs. Physician attitudes may be one of the largest barriers to implementing preventive practices because much of the control in the patient encounter is theirs. Traditional medical education until recently has focused on disease, not on prevention. Convincing physicians to change a long-held perspective requires time, scientific evidence, and personal motivation toward change. Physician practice style, especially when it involves a large patient volume, is associated with lower screening rates. Overcoming this barrier may be achieved using printed reminders to physicians since this method is unobtrusive and interferes minimally with the practice style.[6]

The cost of program implementation is another complex and challenging barrier cited by researchers.[8] Prevention is proven to save costly treatment of disease; however, not the amount of disease nor the dollars saved can be directly measured, and the results are delayed. Patients will not usually see direct benefits of preventive screening if the prevention has been effective, and insurers change so quickly in today's medical arena that money spent today benefits a customer that is likely to be with another insurer tomorrow.

Start up expenses, personnel time for design, set up, training, resources, supplies, equipment, and consultation are prohibitive for many practices. Additionally, maintenance cost reimbursement for a preventive medicine screening system is not specifically provided for or reimbursed by most managed care organizations. A 1992 study found that maintaining an effective computer-based tracking system cost 72 cents per patient per year that was not recovered through increased patient revenues.[8]

Paper charts were found to be costly to maintain effectively and significantly inferior to computerized systems.[2] Computerization in medicine is quickly moving from an option to a requirement to be competitive and provide quality care. To successfully implement a preventive care program, providers must go several steps beyond screening—they must follow up. Abnormal tests require further investigation, action, or referrals to specialists. If not done, the benefits of prevention are lost.[9] Finally, commitment and willingness to change will be required on the part of the office staff as well as the physician to institute a successful preventive screening program.

Institutionalization of preventive care in primary care medicine may best make use of a combined approach. Certain interventions were found to be most consistently and successfully performed at health maintenance visits while others were better incorporated into routine office visits. Patients who scheduled health maintenance visits were two times more likely to have a flexible sigmoidoscopy performed and 18 times more likely to have a clinical breast exam performed.[3] The health maintenance examination is believed to be extremely successful because busy practitioners have little time to incorporate preventive services into routine patient care. Items such as advance directive counseling appeared to fit well into the routine health visit when the physician is provided with a reminder placed on the chart at the time of the office visit.[4]

Prevention fits nicely into the goals of managed care in spite of the initial costs to implement it. It is in keeping with the long-term strategy of reducing hospital admissions and length of stay. Prevention of disease is also the lowest level of care possible. Although there are costs up front, it ultimately and significantly reduces the use of expensive tests and therapies to treat disease down the road.

Prevention is a focal point for managing quality of care. Prevention, like quality assur-

ance, relies on planning and goals. A successful program involves always striving for best of class standards. Just as quality of care is related to expectations, if patients expect preventive care and ask for it directly, quality will improve. Employers and patients must insist on preventive care and be willing to pay for it. Physicians need to be proactive in prevention, setting goals, working to attain them and following up.

The analysis and recommendations concerning preventive care in daily practice include several points. Managed care operates by shifting the risk to physicians and hospitals. It is time for managed care organizations to step up and support physicians by providing the technology, funding, and incentives to promote long-term management of care through prevention. Managed care organizations will succeed by rewarding physicians and patients for being proactive in prevention.

Conclusion

Physicians must shift their thinking toward prevention, becoming more aggressive in goal setting and follow-up. Evidence-based medicine is providing the technology through information on the value of available preventive tools.

Preventive care could have an immediate effect in the U.S. as impoverished Americans suffer a disproportionate cancer burden and a survival rate that is 10% to 15% lower than the general population.[2] Economically poor Americans often have poorer access to health care, are uninsured or underinsured, and are seen at clinics with fewer resources leading to the risk of substandard care. Late diagnosis, lack of health care access, or lack of screening places them at an increased risk for poorer cancer outcomes.[2]

Where does the motivation reside to change the current environment of preventive medicine? It resides with the patient, who is the least educated about the process, but has the most to gain. It also resides with the physician who directs the patient encounter and identifies health-related goals. Lastly, the direction also resides with managed care, which is shaping medicine, having much to offer and much to gain.

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Clinical Preventive Services for Normal-Risk Adults (18 years and older) Recommended by Most U.S. Authorities

Screening:

Ages[1]	Who	Screening	How Often
18-75 years	Men and women	Blood pressure	Periodically
18-75 years	Men and women	Height and weight	Periodically
18-75 years	Men and women	Dental	Periodically
18-75 years	Men and women	Alcohol use	Periodically
18-75 years	Women	Pap smear	Every 1-3 years
35-65 years	Men	Cholesterol	Every 5 years
45-65 years	Women	Cholesterol	Every 5 years
50-70 years[2]	Women	Mammography	Every 1-2 years
50-75 years	Men and women	Sigmoidoscopy	Every 5-10 years
50-75 years	Men and women	Fecal occult blood	Yearly
65-75 years	Men and women	Vision	Periodically
65-75 years	Men and women	Hearing	Periodically

[1] Upper age limits should be determined on a case-by-case basis.
[2] See counseling section for mammography recommendations.

Immunization:

Ages	Who	Screening	How Often
18-75 years	Men and women	Tetanus-Diphtheria	Every 10 years
18-75 years	Men and women who have not had chicken pox	Varicella (chicken pox)	Once (2 doses)
18-50 years	Nonimmune women of child-bearing age	Measles, mumps, rubella	Once (1 dose)
65-75 years	Men and women	Pneumoccoccal	Once in a lifetime
65-75 years	Men and women	Influenza (flu)	Yearly

Patient Handout #4

Counseling:

Your health care provider should take time to discuss the following topics with you:

Who	Topic	How Often
Women ages 18-75 years	Calcium intake	Periodically
Women of childbearing age	Folic acid	Periodically
Peri- and postmenopausal women	Hormone replacement	Periodically
Women ages 40-75 years	Mammography	Periodically
Men ages 50-75 years	Prostate cancer	Periodically
Men and women	Tobacco cessation	Periodically
Men and women	Drug and alcohol use	Periodically
Men and women	Sexually transmitted diseases and HIV	Periodically
Men and women	Family planning	Periodically
Men and women	Domestic violence	Periodically
Men and women	Unintentional injuries	Periodically
Men and women	Seat belt use	Periodically
Men and women	Nutrition	Periodically
Men and women	Physical activity	Periodically
Men and women	Polypharmacy	Periodically
Elderly men and women	Fall prevention	Periodically

Source: *Put Prevention Into Practice (PPIP), a national, research-based public-private program aimed at increasing the appropriate use of clinical preventive services (screening, immunizations, and counseling). The U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion (ODPHP) developed PPIP and in 1998 transferred management of the project to the Department's Agency for Healthcare Research and Quality (AHRQ), formerly the Agency for Health Care Policy and Research.*

Patient Handout #4

State of the State's Health

Oklahoma State Board of Health

Introduction

The State Board of Health presents its fourth annual *State of the State's Health* report to the citizens of Oklahoma. Our first report in 1997 provided a snapshot of the state's health. Unfortunately, we compared poorly to the rest of the nation. The 1998 report found considerable regional differences in health status. The data revealed that we have been losing ground compared to the rest of the nation, especially in the last decade. The third report in 1999 examined public health indicator trends and focused on critical issues related to the health of our younger population. Although we reported some positive progress in certain areas, such as decreasing death rates over time for heart attacks, perinatal conditions, unintentional injuries, and birth defects, our improvement did not match the United States as a whole. Furthermore, we were alarmed by significant problems among our youth, including high rates of tobacco addiction, motor vehicle crashes, suicide, and teen pregnancy. We concluded with a proposed action agenda and stated, "The Board of Health and the Oklahoma State Department of Health cannot improve current health conditions alone. Interventions will have to be initiated one step at a time, and most often by local communities, neighborhoods, and families."

This 2000 report represents a departure from our first three reports. While we continue to examine health data trends, we will focus particularly on *solutions*. We are at a turning point in Oklahoma's future health and well-being. Unless we act together, now, with a planned approach, we may be unable to reverse the trends of poor health we have been experiencing as a state. Physicians, public health professionals, business leaders, state government, our faith communities, and others simply *must* work together. Coordinated prevention activities must be our top priority.

Health Status Indicators

Behavioral Risk Factors

Oklahoma's *smoking* rate continues to be higher than the national average. In 1998, the Centers for Disease Control and Prevention (CDC) reported through the Oklahoma Behavioral Risk Factor Surveillance System (BRFSS) that Oklahoma's adult smoking rate was 23.8% compared to a national median of 22.9%. Even more distressing is the fact that Oklahomans who smoke consume more cigarettes than much of the nation, 111.8 packs per capita compared to 86.9 packs per capita for the U.S. (CDC, *State Tobacco Control Highlights*, 1999). In addition, 42% of our high school students are currently at risk for lifelong nicotine addiction, a rate considerably higher than the rest of the nation. Until our state leaders seriously consider the impact smoking has on the health of our citizens and act accordingly, we will continue to see high rates of lung cancer, emphysema, heart disease, stroke, and other conditions directly related to this addiction. Appropriate use of tobacco settlement funds can make a powerful impact on improving the health of Oklahomans. If not, the burden of tobacco use will continue to plague our citizens disproportionately compared to the U.S. as a whole.

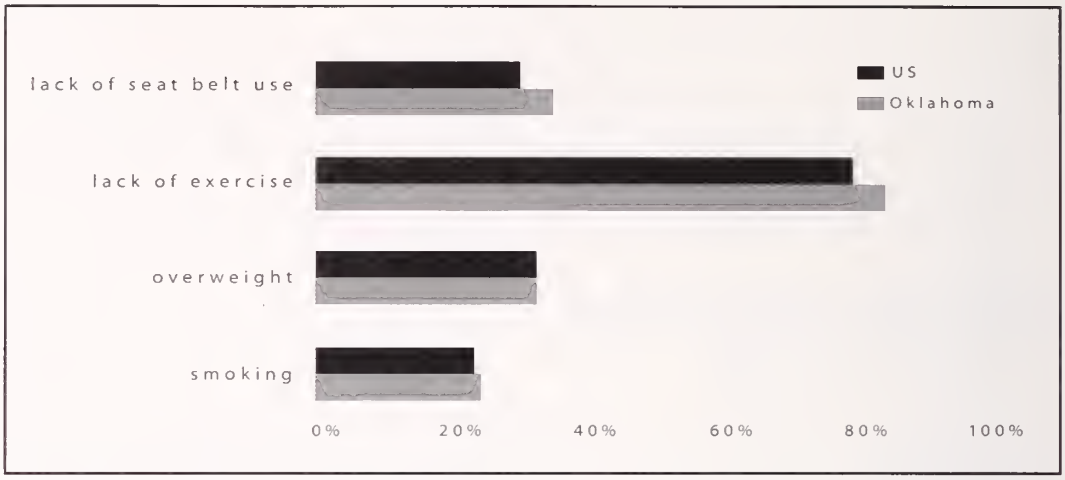


Figure 1. Behaviaral Risk Factars, US and Oklahoma, 1998

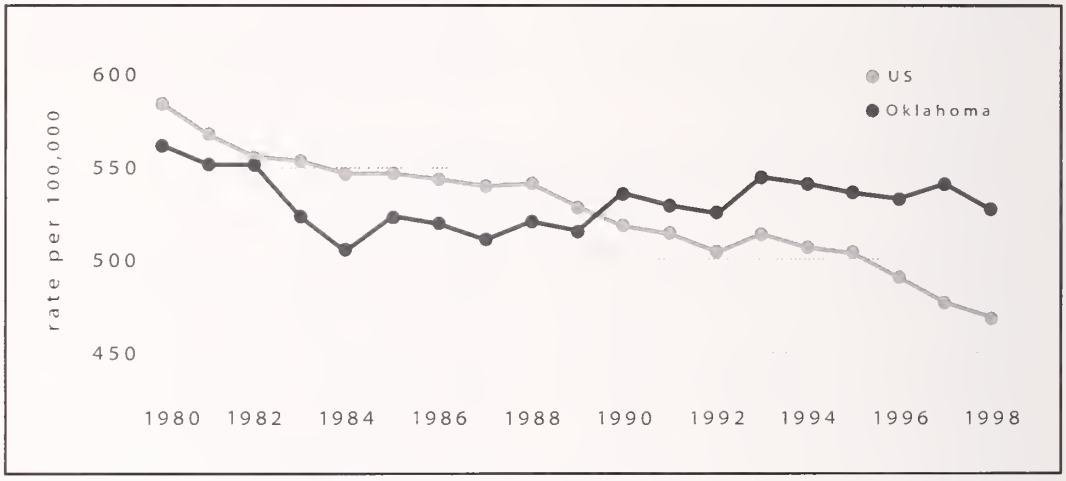


Figure 2. Age Adjusted Death Rates for All Causes, US and Oklahoma

Another risk factor of concern is *overweight*. In 1998, CDC, through the BRFSS, reported that 32.4% of Oklahomans were at risk for health problems related to being overweight, again higher than the nation. This may be in part due to lack of exercise. According to CDC, 84.3 percent of Oklahomans are at risk for health problems related to lack of regular and sustained physical activity compared to a national average of 79.7%. This combined effect of overweight and lack of exercise puts far too many of our citizens at risk for serious conditions, such as high blood pressure, stroke, heart disease, type 2 diabetes, and osteoarthritis.

Motor vehicle crashes continue to be the leading cause of injury death in Oklahoma. Oklahoma's age adjusted death rate for motor vehicle injuries is 24 per 100,000 compared to 16.2 per 100,000 for the U.S. (CDC, *Oklahoma State Health Profile*, 1999). Although Oklahoma's seat belt use has increased over the years, we still lag behind the rest of the nation. In 1997, our rate for lack of seat belt use was 36.9% compared to a national rate of 30.8% (Oklahoma BRFSS).

Oklahoma has a high percentage (50 percent) of *firearms* available in its homes. Easy access to firearms may in part explain Oklahoma's gun-related homicides and suicides.

Another concern is our high rate of *unwanted pregnancies*. For several years in a row, the data have shown that a child born as a result of

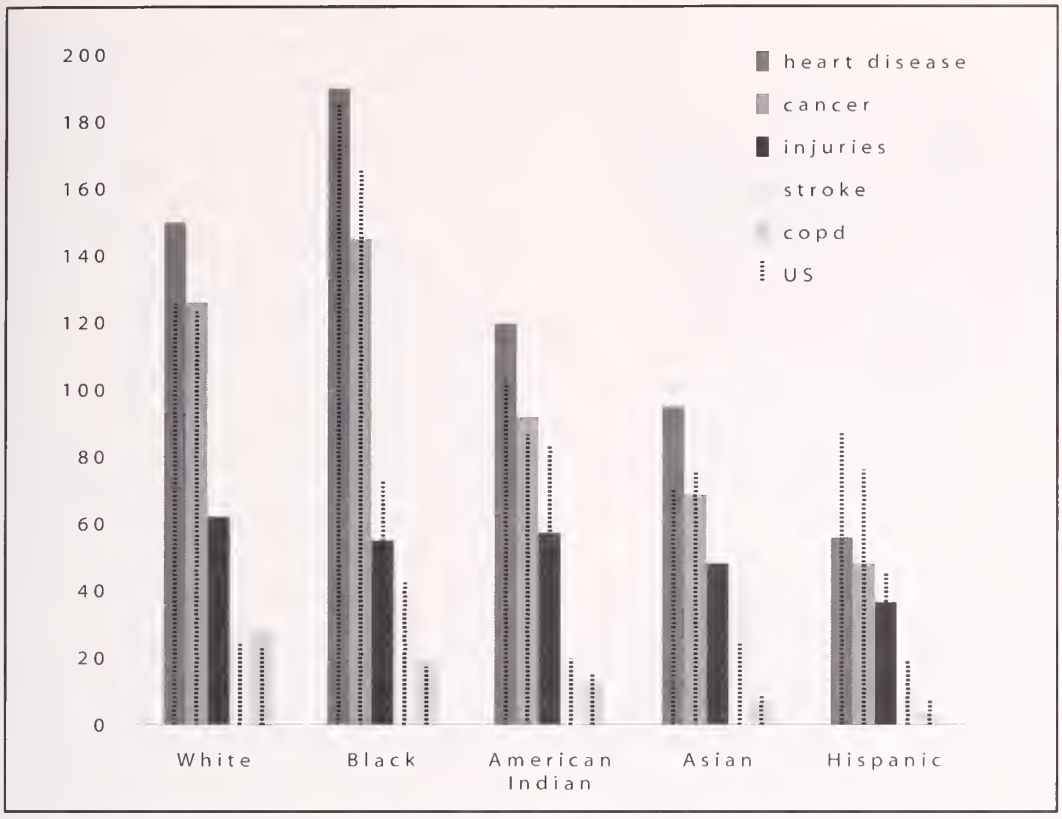


Figure 3. Age adjusted death rates per 100,000 population, US and Oklahoma

an unwanted birth is much more likely to be at risk for numerous health problems, including child abuse. Three-quarters of our births to teens are unintended. Chances for these children living in poverty are three times greater than for mothers who delay childbearing until after the age of 20.

Leading Causes of Death

As seen in the 1999 *State of the State's Health* report, Oklahoma's leading causes of death are heart disease, cancers, injuries, stroke, and chronic obstructive pulmonary disease. Unfortunately, Oklahomans die from these causes at a higher rate than the rest of the nation. Taking all causes of death into account, Oklahoma's 1998 age-adjusted death rate per 100,000 population was 530.2 compared to a national average of 470.8 (CDC, *National Vital Statistics Report*, 10/5/99). This 11.3% higher rate is absolutely unacceptable. Because of our high death rates, we have far too many years of productive lives being lost in Oklahoma (CDC, *Oklahoma State Health Profile*, 1999).

Also, as described in our 1999 report, we are concerned about the differences we see in death rates within our state. These differences are evident geographically, where one county with low death rates may be next to a county with high death rates. Striking differences are also seen among race and gender groups in Oklahoma (CDC, *Oklahoma State Health Profile*, 1999). Why such differences?

Underlying Causes

We know *what* diseases and injuries are making Oklahoma unhealthy. But, *why* do we have these problems at rates higher than the rest of the nation? What are the underlying causes? The behavioral risk factors already discussed are a partial explanation, especially nicotine addiction. But there are others.

Economic Reasons

Numerous studies show a strong association between income and poor health outcomes. Oklahoma ranks 45th out of 50 states for personal income levels (U.S. Bureau of Economic

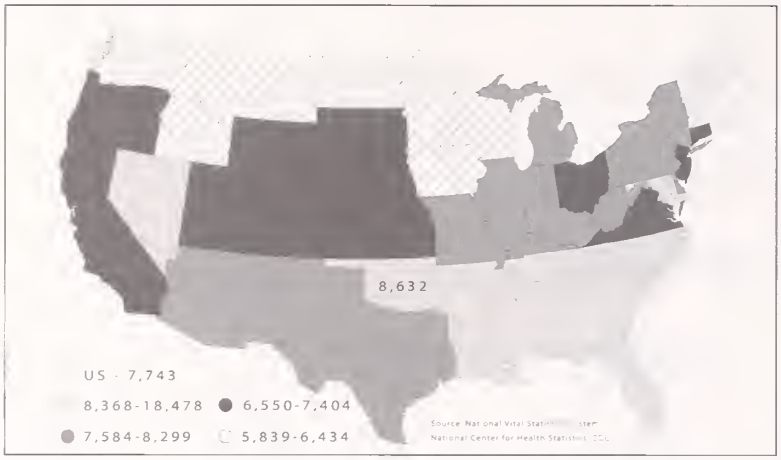


Figure 4. Age Adjusted Years of Potential Life Lost Before Age 75 per 100,000 Population

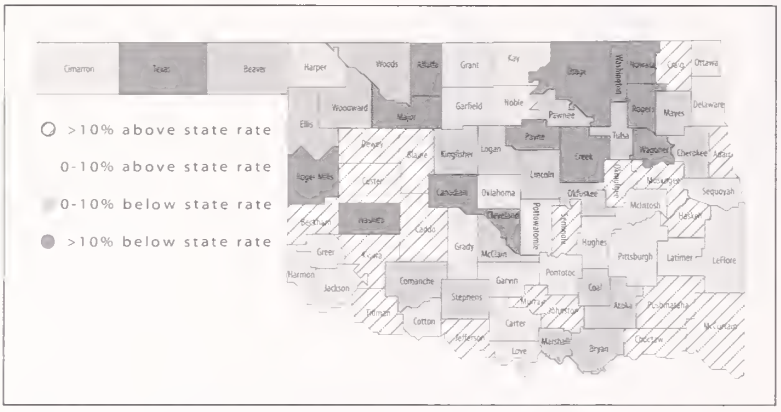


Figure 5. Age Adjusted Death Rates for Oklahoma Counties, 1998

Analysis, 1999). Moreover, Oklahoma's rate of increase for personal income has not kept pace with the national rate of increase as can be seen in Figure 6. Such poor income levels have a particularly significant impact on all of us, but especially on our children. Over 32% (more than 76,000) of Oklahoma's children under age 5 live in poverty (U.S. Census Bureau, February 1999).

Even with risky behaviors such as smoking, income levels play a significant role. As Figure 7 shows, percentages of Oklahomans who smoke increase as income levels decrease (Oklahoma BRFSS, 1998). Nicotine addiction eventually results in health problems, and those with lower incomes are less likely to be able to afford adequate health care. Almost 50% of Native Americans in Oklahoma suffer from nicotine addiction. Socioeconomic factors play a role here as well.

For many, the 1990s represented a time of prosperity. Income levels increased rapidly among various groups. However, this was not the case for everyone. There has been a disturbing trend in an increase in the gap between the "haves" and the "have-nots." Figure 8, based on national data from the U.S. Census Bureau, shows the widening gap between those with the highest and lowest incomes. Such disparities in income only augment the disparities in health outcomes that we see between the wealthy and the poor.

Lack of Access to Health Care

Another underlying cause of Oklahoma's poor health status indicators is lack of adequate access to health care. Health insurance coverage, in particular, continues to be a problem. According to CDC's BRFSS data, 22.5% of Oklahomans between the ages of 18 and 64 did not have health insurance coverage in 1998. This represents more than 532,000 people. When people do not have health insurance, they are more likely not to seek routine health care, especially preventive measures such as check-ups and screenings. Preventive measures and screenings are especially important because early detection for possible problems such as cervical cancer, breast cancer, or heart disease can make all the difference in a successful treatment outcome. In addition, lack of access to routine health care often results in the use of emergency rooms for treating non-emergency conditions—an expensive option that drives up the cost of health care for everyone.

Inadequate Community Health Resources

Between 1990 and 1998, 24 of Oklahoma's 77 counties experienced a decrease in population (U.S. Census Bureau). As we see our population distribution shift from rural to urban, those remaining in rural counties are at risk for hospital closings and lack of medical care. This is a growing concern for Oklahoma.

Solutions

So, we know in some measure what is making Oklahoma unhealthy. Now, it is time for us to consider and implement solutions. This important work for the future of our state's health cannot be done in a vacuum. Neither the State Board of Health or the Oklahoma State Department of Health can do this work alone.

It requires a collaborative, cooperative effort between concerned citizens, physicians, business leaders, public health workers, faith leaders and others in our state who want to make difference. At the very least, our children deserve a healthier future. ***Their future is tied to what we do now!***

Clinical Prevention

"An ounce of prevention is worth a pound of cure" rings as true today as it did over 200 years ago when first written by Benjamin Franklin. Reduction of risk factors through lifestyle behavior changes and appropriate preventive measures is a very basic, yet extremely important change that is needed in our health care delivery system. There will always be a need to treat those who are ill through primary care and medical specialties. However, physicians can have a powerful impact on preventing disease by stressing prevention in their clinical practices. For example, many deaths from heart attacks, Oklahoma's leading cause of death, can be prevented by the appropriate, early administration of beta blockers for those at risk.

Some clinical preventive practice efforts are already underway. The Oklahoma Foundation for Medical Quality is working with physicians and hospitals to improve the health of Medicare recipients by focusing on preventive measures for some of Oklahoma's leading causes of death, including heart attack and stroke. The Oklahoma State Medical Association's "Physicians' Campaign for a Healthier Oklahoma" will emphasize clinical prevention practices, healthy message reminders for patients, and physician involvement in community prevention initiatives.

We call on physicians to participate in such efforts and join us as partners in promoting preventive practices for Oklahoma.

Individuals must do their part as well. It is an individual's responsibility to adopt behaviors conducive to health, such as not smoking, exercising regularly, and maintaining a healthy diet. Taking responsibility for your health and working together with your physician on prevention can lead to a lifetime of high quality, healthful living.

Statewide Initiatives

We have identified tobacco use as the one behavioral risk factor that has the most negative impact on the health of Oklahomans. Therefore, we recommend the immediate implementation of a statewide, comprehensive, evidence-based tobacco prevention and reduction program that includes surveillance systems, community-based programs, media campaigns, school-based education, cessation products and services, and program evaluation. Funding for this statewide tobacco use prevention initiative should come from tobacco settlement funds. The Oklahoma State Department of Health

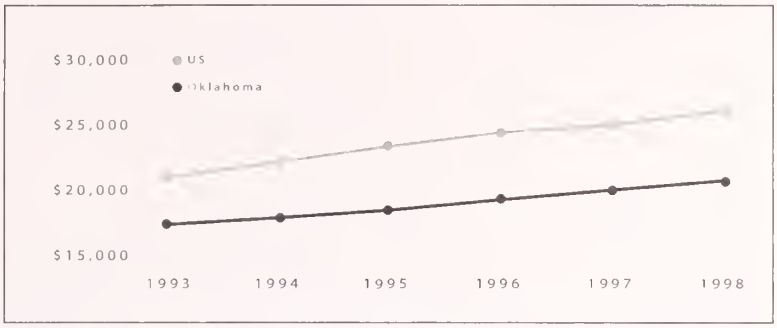


Figure 6. Personal Income Levels, US & Oklahoma, 1993-98

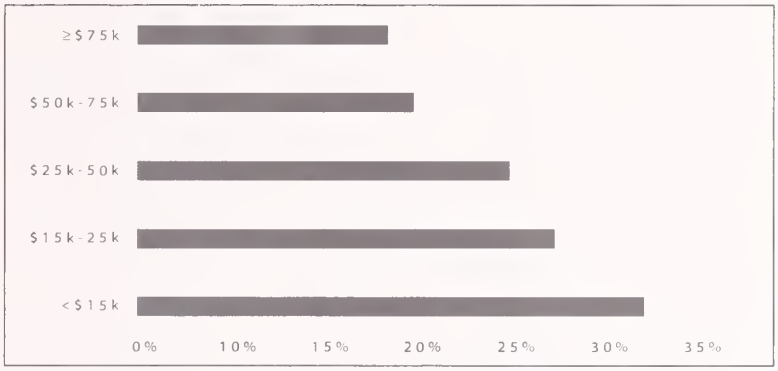


Figure 7. Percent of Current Smokers by Income Level, Oklahoma

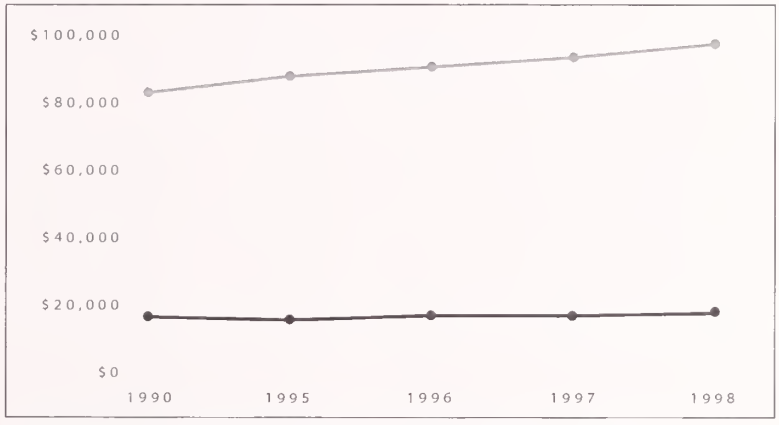


Figure 8. Comparison of US Highest and Lowest Incomes, 1990-98

should coordinate the tobacco use prevention initiative, serve as a technical resource, and assist in data collection and evaluation. However, the implementation of interventions should be done at the community level by community partners.

Unwanted and unintended pregnancies must decrease. The negative health and socioeconomic outcomes associated with unwanted and unintended pregnancies—including high rates of low-weight births, physical violence, and poverty—are unacceptable. Therefore, we recommend the immediate implementation of a statewide initiative to reduce unwanted and unintended pregnancies, especially among teens, through appropriate, comprehensive educational and preventive measures. Funding for such a program should be similar to the successful Children First program, with the same commitment to quality, follow-up, and evaluation.

A Partnership Approach to Public Health Decision-Making

Our final recommendation is to formally endorse a process in Oklahoma that will result in a fundamental change in how we approach public health and prevention. In the introduction of this report, we said that coordinated prevention activities *must* be our top priority. If we do not involve the people in the process of change who will be responsible for implementing the change, change will not occur. (To assist with this process, county-specific data is available upon request by calling 405/271-4200.)

A process that has been developed to implement such change through a coordinated effort is the Oklahoma Turning Point Initiative. Based on the notion of shared responsibility for health, Turning Point seeks to impact health at the community-level, through the active participation of physicians, public health professionals, business leaders, state government, our faith leaders and other community partners in decisions about public health and prevention activities. The foundation for restructuring public health in Oklahoma through community-based decision making has been established in the *Oklahoma Public Health Innovation Plan* prepared by the Oklahoma Turning Point Advisory Committee and the Oklahoma community Turning Point partners. This plan, with its recommendations, should be fully implemented with the emphasis of assisting other communities in developing Turning Point partnerships across Oklahoma.

Conclusion

We can wait no longer. We are at an urgent point in time. If we do not make the right decisions about our state's public health and health care systems, we may witness a spiraling trend toward worsening health status. It is critical that we enter the new millennium with a renewed spirit to create an improved state of health. The work we do now will have a lasting impact on our people. Collaboration and cooperation are the keys. Together, as partners, we must think differently about our preventive approaches, coordinate our efforts, and challenge ourselves to take risks that will ultimately improve the health of Oklahoma's future generations. J

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State Health Agency Promotes "Safe at Home" for Child Abuse Prevention Month

Molindo Reddish Douglos, MPH, Epidemiologist; Corol Gehue, Progrom Consultant Office of Child Abuse Prevention, Oklohomo Stote Deportment of Heolth

On the eve of April's observance of Child Abuse Prevention Month, the Oklahoma State Department of Health has launched a public awareness and outreach program to help ensure that children in Oklahoma are truly ***Safe at Home***.

From 1993 to 1997, the overall crime rate in this country fell 21%, meaning that most of us are safer today than we were six years ago. During this same period of time, however, reports of child abuse and neglect rose by 9%, according to *Prevent Child Abuse America*, the nation's leading child abuse prevention organization.

In Oklahoma, the rise in child abuse and neglect cases is even more staggering. The number of confirmed child abuse and neglect cases doubled from 8,359 in 1993 to 16,710 in 1998, according to the Department of Human Services' reports.

Since its first presidential proclamation in 1983, Child Abuse Prevention Month is observed each year in April. This is an excellent opportunity to remind ourselves of our collective responsibility to prevent the abuse and neglect that robs so many of our children of their childhood, their sense of security and well-being, and their future.

Physicians who have opportunities to counsel parents can offer the following parental tips that can help make children ***Safe at Houe***:

- **Be a nurturing parent.** Children need to know that they are special and loved. Educate yourself about a child's development process so you can have reasonable expectations about what your child can and cannot do.

- **Help a friend, neighbor or relative.** Being a parent isn't easy. Someone you know may be struggling with his or her parenting responsibilities. Offer a helping hand.

- **Help yourself.** When the big and little problems of everyday life pile up to the point you feel overwhelmed and out of control, take time out. Don't take it out on your child. Take a deep breath. Turn on some music. Know where you can find help should you need it.

- **If your baby cries...** It can be frustrating to hear your baby cry, especially when nothing you do seems to work. Learn what to do if your baby won't stop crying. But never shake a baby!

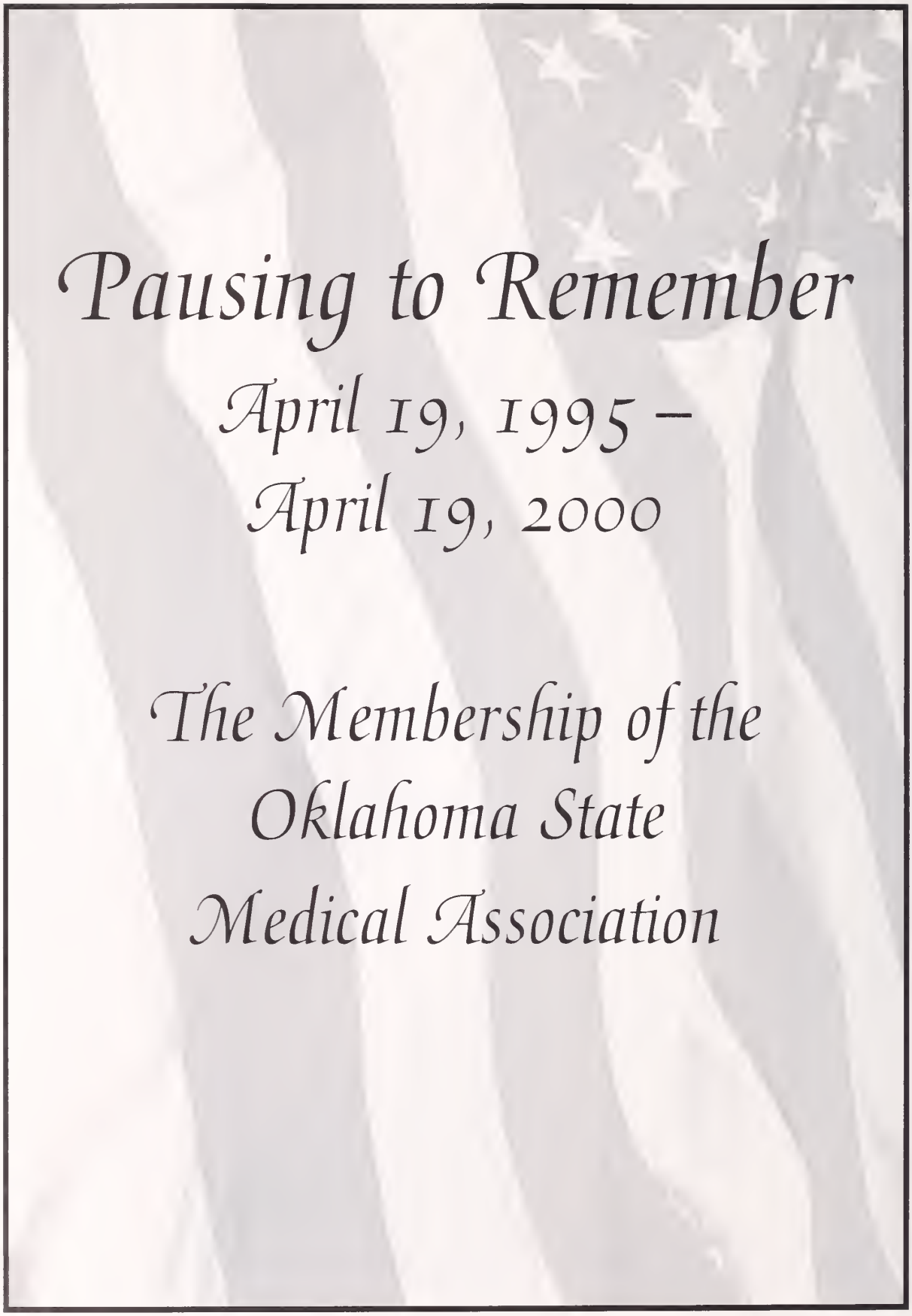
- **Get involved.** Advocate for services to help families. Ask your community leaders, clergy, library, and schools to develop services to meet the needs of children and families.

- **Monitor your child's television and computer use.** Watching violent films on TV or playing violent computer games can harm young children. Not only does it scare them, it also teaches children that aggression is a good way to handle frustration and solve problems.

- **Spend time playing with your children...** or read to them instead!

The Oklahoma State Department of Health's Office of Child Abuse Prevention promotes the health and safety of children and families by reducing violence and child maltreatment through education, multidisciplinary training of professionals, and the funding of community-based family resource and support programs.

For more information about how to use the office's resources to prevent child abuse and neglect or to get involved in Child Abuse Prevention Month activities, call the Office of Child Abuse Prevention at (405) 271-4470. If you have reason to believe a child has been—or may be—harmed, call the Child Abuse and Neglect Reporting Hotline at 1-800-522-3511.


Pausing to Remember
April 19, 1995 –
April 19, 2000
The Membership of the
Oklahoma State
Medical Association

Resident Award to be Established in Memory of Perry Lambird, MD



The University of Oklahoma College of Medicine Department of Pathology is establishing a permanent endowment of at least $10,000 to fund an award to be named in honor of Perry Lambird, MD. This award will be named the "Perry Lambird Pathology Resident Award" and will be given in recognition of the contributions of Dr. Perry Lambird to the practice of pathology in the state of Oklahoma.

Dr. Lambird was an outstanding pathologist and administrator who provided pathology services for the citizens of Oklahoma and surrounding states. He also was a leader in regional and national pathology professional organizations. This Perry Lambird Pathology Resident Award will be presented annually to the outstanding pathology resident in the residency training program of the University of Oklahoma College of Medicine Department of Pathology, who demonstrates excellence in all aspects of pathology including service, laboratory management skills, and teaching of medical students and residents in pathology and other programs. Qualifications for this award will be established by an awards committee of the Department of Pathology.

The award recipient will receive an individual plaque indicating the award, will have his or her name placed on a large plaque displayed in the Department of Pathology, and will receive a monetary award. All of this will be funded by interest from the endowment. The endowment account for this award has been established at the University of Oklahoma Foundation. Oklahoma physicians are encouraged to contribute to this endowment to honor Dr. Lambird and his tireless efforts on behalf of the medical community in Oklahoma. Contribution checks should be made out to the University of Oklahoma Foundation "Perry Lambird Pathology Resident Award" and sent to: Lambird Award, c/o Department of Pathology, Attn: Judy Roden, PO Box 26901, Oklahoma City, OK 73190. Contributions of securities are also welcome and should be made to "Salomon Smith Barney Inc. account 73-6091755 of the University of Oklahoma Foundation, Inc."

Area Physicians Announce Community Service Projects

Members of the Payne-Pawnee-Noble County Medical Society are providing donations to community service projects, including an Adoption Match Party to be held May 6. The event is intended to bring together adoptable children and pre-approved prospective adoptive parents. The medical group has pledged to underwrite the cost of food for the event as well as donating skateboard helmets for some of the participating children.

Other projects selected by the doctors include sponsoring the new American Medical Student Association Premedical Chapter at Oklahoma State University and providing funds toward the purchase of infant care safety seats through the Health Department, according to Woody Jenkins, MD, President.

"Our organization had some money in the bank, and we wanted to put it to good use," he said. "We felt that these projects—all of which benefit children and young adults—were worthwhile projects and deserved our support. The greatest asset any community has is its children. And while our physician members donate countless hours to youth projects on an individual basis, we also wanted—as a group—to provide some financial resources for these particular activities as well."

Zingarelli Appointed Cancer Liaison Physician

William Joseph Zingarelli, MD, of Lawton, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Comanche County Memorial Hospital. The Cancer Liaison Program is part of the Commission on Cancer of the American College of Surgeons. Dr. Zingarelli is among a national network of over 1,800 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program, and other Commission on Cancer activities.

Dr. Zingarelli, who has a significant interest in the diagnosis and treatment of patients with malignant diseases, provides leadership to the cancer committee at his appointed institution in order to maintain their Commission-approved cancer program. Dr. Zingarelli also provides community leadership by volunteering at the division or unit level of the American Cancer Society to develop cancer control initiatives.

Organ Sharing Network Proposes Definition of Imminent Death

As part of the Clinton Administration organ donation initiative, the Department of Health and Human Services, in August of last year, implemented new Medicare Conditions of Participation (COP) in regard to organ donation. While having little immediate effect on organ donation rates within Oklahoma, the COP has impacted heavily on both Oklahoma hospitals and the Oklahoma Organ Sharing Network (OOSN) in terms of both compliance and documentation of compliance with the various new requirements. Most notable among the new requirements placed on hospitals by the COP is the requirement that the organ procurement organization (OPO) be notified, in a timely manner, *of individuals whose death is imminent or who have died in the hospital.*

While the Health Care Financing Administration (HCFA) has not attempted to define imminent death, it has been suggested in a document entitled *Hospital Conditions of Participation for Organ Donation, Questions and Answers* that any definition of imminent death "would include a brain dead or severely brain-injured individual on a ventilator."

In regard to the question dealing with the meaning of "timely notification," the same question and answer document states the following:

> Timely notification means that a hospital must contact the OPO by telephone as soon as possible after an individual has died, has been placed on a ventilator due to a severe brain injury, or who has been declared brain dead. That is, a hospital must notify the OPO while a brain dead or severely brain-injured, ventilator dependent individual is still attached to the ventilator and as soon as possible after the death of any other individual, including a potential non-heart-beating donor. Even if a hospital does not consider an individual who is not on a ventilator to be a potential donor, the hospital must call the OPO as soon as possible after the death of that individual has occurred.

HCFA further maintains that hospitals are expected not only to report imminent deaths to the OPO, but they are also expected to work cooperatively with the OPO, tissue bank, and eye bank to maintain potential donors while necessary testing and placement of potential organs, tissues, and eyes takes place.

Upon consideration of both the regulation and the explanatory information provided in the question and answer format, it became apparent that a clear definition of imminent death was required. In an effort to facilitate such a definition, the OOSN executive committee, utilizing the Glascow Coma Scale, has proposed the following for consideration of physicians and hospitals throughout Oklahoma:

> Imminent death shall be considered present when a patient has a score equal to or less than four (4) on the Glascow Coma Scale.

It is the belief of physicians comprising the OOSN executive committee that when possible factors such as hypothermia, shock, drug intoxication, and neuromuscular blockade have been ruled out, a Glascow Coma Scale score of 3 or 4 will prove a useful and conservative definition of imminent death. Such a definition should prevent premature and/or unnecessary patient referrals; encourage appropriate referrals for early evaluation relative to potential for organ donation; and at the same time allow Oklahoma hospitals to meet and clearly document meeting requirements of the COP on organ donation.

OOSN has proposed the above definition for the purpose of soliciting input from the physician community. Comments and suggestions can be addressed to either E.N. Scott Samara, MD, President, or Robert Turner, Executive Director, in care of the Oklahoma Organ Sharing Network, 5801 North Broadway, Suite 100, Oklahoma City, OK 73118.

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Letters to the Editor

To the Editor:

The 2000 OSMA Annual Meeting will be held May 5-7 at the Westin Hotel in Oklahoma City. Several important issues pertaining to the future of medicine will be debated during both the Reference Committees and the Closing Session of the House of Delegates. Some of these items will include the following: (1) AMA deunification; (2) proposed 2001 dues increase of $100; and (3) the 2000 OSMA deficit budget. After reading the March issue of the OSMA *Journal*, I felt it was appropriate to respond to some of the issues raised in both the editorial, written by Dr. Pontious, and the President's Page, written by Dr. Whitlock.

AMA deunification—In my opinion, deunification from the AMA is a ***"freedom of choice"*** issue. Currently, only four states (Oklahoma, Mississippi, Illinois, and Delaware) remain unified with the AMA. During 1999, both Oklahoma and Tulsa counties conducted surveys pertaining to deunification. The results from the OCMS survey are: 1,314 surveys were mailed and 523 surveys were returned, with **357 in favor of deunification, 165 not in favor of deunification, and 1 undecided.** Eighty-eight percent (88%) of Tulsa County's delegation voted in favor of deunification. Based on these results, OCMS and TCMS have each submitted an AMA deunification resolution to be debated and voted on at this year's meeting. Should this effort pass, a physician can **still** be a member of the AMA—it simply will not be a requirement. Those who choose to do so may remain "involved" in national issues. The OSMA will still send a delegation to the AMA meetings in an effort to represent the "voice" of Oklahoma physicians. The **only** change will be "choice."

Proposed 2001 dues increase—Some members of the OSMA leadership support a proposed 2001 "cost of living" dues increase in the amount of $100. Instead of the OSMA placing an additional financial burden on its members, perhaps it should take a page out of the "AMA's Playbook"—cut back! I recently received an AMA memorandum pertaining to its "repositioning" efforts, namely a $20 million strategic scale-back and restructuring of AMA programs and staffing. These changes will be implemented as of March 31, 2000.

OSMA deficit budget—The "original" proposed 2000 OSMA budget projected expenses over revenue in the amount of $321,046. Following a meeting between the leadership of the OSMA and OCMS, the budget was "reworked" in an effort to decrease the deficit. Never in the history of our state organization has a "deficit" budget been presented to the House of Delegates for approval. I ***agree*** with Dr. Whitlock that an "aggressive" approach should be taken in the area of OSMA's finances but ***disagree*** with him on the direction of this approach. The OCMS leadership is committed to being fiscally responsible. There has not been an OCMS dues increase since 1988. We currently employ three full-time staff members, and this number has remained constant for at least 20 years. Still, the Society continues to implement new programs for its members and for the benefit of our community.

There are many issues facing physicians and the House of Medicine. The OSMA must get its own "house" in order before it can be an effective voice for the physicians it represents.

V. Ramgopal, MD, President
Oklahoma County Medical Society

Letters to the Editor
may be sent to:
J. Michael Pontious, MD
Editor-in-Chief
OSMA *Journal*
601 West I-44 Service Road
Oklahoma City, OK 73118

To the Editor:

Congratulations on an excellent editorial in the March issue of the *Journal*. I couldn't agree more. With the limited voice Oklahoma medicine has on a national level, the last thing we need to do is isolate ourselves and become alienated from organized medicine.

Our best bet is to develop strong leadership in Oklahoma to represent our views on a national level. Of course, we don't always agree with the AMA—that's not the point.

Physicians must learn that united we stand, divided we fall, in the face of adversity. For too long we have been our own worst enemy, playing into the hands of those who profit by our division.

Joe Haines, MD
Perkins, OK

Letters to the Editor (continued)

To the Editor:

This is in reply to your editorial in the March 2000 issue of the *Journal of the Oklahoma State Medical Association*. Most physicians that I know are members of the Republican Party. One of the mainstays of the political beliefs of the Republican Party is freedom of choice. That is the freedom to join a union or not to join a union. The requirement that all members of the Oklahoma State Medical Association be members of the American Medical Association is nothing more than a form of forced union membership. I will be the first to admit that this is a crude analogy, as there is a vast difference between a union and a professional organization such as the AMA. Nevertheless, it is an appropriate analogy that is easy for all concerned to understand.

If members who support unification say that they are for personal freedom and individual choice, then they are talking out of both sides of their mouth, as this is clearly not what is represented by the Oklahoma State Medical Association. It should be my choice as to whether I want to be a member of the American Medical Association, not a decree by the Oklahoma State Medical Association.

Another analogy: How many members of the Oklahoma State Medical Association who support unification supported Hillary Care? A one-size-fits-all health plan. A plan to be forced upon every member of society whether they want it or not. No way. Members of the Oklahoma State Medical Association want freedom of choice in selecting their health plan. Likewise, I want freedom of choice as to whether I want to be a member, or not to be a member, of the AMA.

If you want to be a member of the AMA, that is your choice, but your choice should not be forced upon me.

Michael L. Soper, MD
Muskogee, OK

To the Editor:

Thank you for such a good editorial. I really wanted to comment on it and disagree with you.

1. There is an element of coercion present. That is, one cannot join PLICO unless they belong to certain organizations, which are unified in their structure. In my opinion, this is an example of coercion. One might also look at it as being a good business arrangement—depending on how you look at it from the moral standpoint.

2. I personally take umbrage at some of what the AMA does. I don't believe our delegations are going to ever represent my views on the issues. Hence, it is my opinion that I should be outside the AMA, although I have stayed inside of it since I was a young physician finishing training in the 1950's.

3. My particular views are those of pro-life, anti-abortion, with particular emphasis on late-term abortion. The AMA has vacillated back and forth on these issues but have not taken a clear stand for life. If we physicians do not stand up for life, believe me, we will be used as the German physicians were in the 1930's. I am a great student of what happened before the Holocaust, as well as during the Holocaust, and how the German's entire medical establishment was co-opted by their own journals, their own boards to do what the government wanted them to do.

4. You ask what we get for your money? I get a journal and very little else. I do not believe that the lobbying the AMA does is effective in Washington, more than a three to five percent level. I believe that the AMA is replete with money. I was raised in Chicago, trained there, and am aware of what goes on in their headquarters. The whole concept of ever having reams of oil paintings of high quality—and high cost—is unethical to a leading organization. Dues should not be spent for artwork!

I am not sure that you do not agree with any of these points as noted above, but I did want you to know my opinion.

Ernest G. Warner, MD
Oklahoma City, OK

Editorial reply: As your Editor-in-Chief, I have finally struck a nerve. The phone in my office has been ringing off the wall; the mail and discussion that my March editorial has stimulated has been anxiety-provoking. Your comments have been heartfelt and sincere.

This editorial was printed in March so that there would be time for public debate among our membership, and the opportunity for responses to be published in this issue of the Journal. *If you feel strongly about this issue, you must speak with your delegate to the Oklahoma State Medical Association's annual meeting...or better yet, show up at the meeting.*

As your editor, I am entitled to my opinion. Simply, we occasionally must give up something in order to have a greater voice as a group.

As you can see, there are members of the OSMA who strongly disagree with my stance. The choice will be made by our representation at the annual meeting.

J. Michael Pontions, MD
Editor-in-Chief

Orval L. Parsons, MD
1907-2000

Orval L. Parsons, MD, died on January 29, 2000. Dr. Parsons was born on April 1, 1907 in Enid, Oklahoma. He was a life member of the Oklahoma State Medical Association and received his medical degree from the University of Oklahoma School of Medicine in 1933.

James William White, MD
1916-2000

James William White, MD, died on February 1, 2000. Dr. White was born May 31, 1916 in Poteau, Oklahoma. He was a member of the Oklahoma State Medical Association and received his medical degree from the University of Tennessee Medical School.

James L. Nicholson, MD
1904-2000

James L. Nicholson, MD, died February 3, 2000. Dr. Nicholson, a life member of the Oklahoma State Medical Association, was born on December 31, 1904 in Protem, Missouri. He received his medical degree in 1931 from the University of Oklahoma School of Medicine.

Leo Meece, MD
1930-2000

Leo Meece, MD, died February 5, 2000. Dr. Meece was born in Grandfield, Oklahoma on February 25, 1930. He received his medical degree from the University of Oklahoma School of Medicine in 1960 and was a member of the Oklahoma State Medical Association.

Homer A. Ruprecht, MD
1903-2000

Homer A. Ruprecht, MD, a life member of the Oklahoma State Medical Association, died on February 6, 2000. Dr. Ruprecht was born on August 17, 1903 and received his medical degree from the Western Reserve University, Cleveland, Ohio in 1928. Dr. Ruprecht was preceded in death by his wife, Dr. Marcella Steel.

William G. McCreight, Sr., MD
1911-2000

William G. McCreight, Sr., MD, died on March 10, 2000. Dr. McCreight, a life member of the Oklahoma State Medical Association, was born in Oklahoma City, OK on February 18, 1911. He received his medical degree from the University of Oklahoma School of Medicine in 1940.

1999

Winfred L. Medcalf, MD	April 1
Robert P. Dennis, MD	April 6
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George L. Hill, MD	April 20
Jim M. Taylor, MD	April 28
T. Jeff Williams, MD	May 17
Thomas Ross Ahrend, MD	May 23
Lawrence E.C. Joers, MD	June 5
Fyman J. Drell,	July 15
Lee Bailey Word, MD	July 22
Dave B. Lhevine, MD	July 31
Michael Allan Houghton, MD	August 16
Webb M. Thompson, Jr., MD	August 20
Perry A. Lambird, MD	August 25
Nolen L. Armstrong, MD	September 12
George R. Randels, MD	October 2
George B. Carter, MD	October 7
John Robert DeBiase, MD	October 17
Theodore Turnbull, MD	October 19
Sol Wilner, MD	October 31
Malcolm Horne, MD	November 3
William Clark Cheek, MD	November 11
Bill B. Elrod, MD	November 17
Donald E. Johnson, MD	November 18
Allen E. Greer, MD	November 19
Beverly Colvin Chatham, MD	December 2
Norman A. Cotner, MD	December 3
Alan Knight Braly, MD	December 9
Wilson David Steen, PhD	December 12
James Thermon McInnis, MD	December 18
Douglas Lyons Polk, MD	December 19
Thomas S. Llewellyn, III, MD	December 26
John Preston McDaniel, MD	December 27
Joe Earle Tyler, MD	December 31

2000

Hwan X. Youn, MD	January 2
Donald Charles Barney, MD	January 4
Charles E. Cook, MD	January 13
Lynn H. Harrison, MD	January 16
Kenneth C. Hoffman, MD	January 17
Richard E. McDowell, MD	January 17
Orval L. Parsons, MD	January 29
James William White, MD	February 1
Harry L. Deupree, MD	February 3
James L. Nicholson, MD	February 3
Leo Meece, MD	February 5
Homer A. Ruprecht, MD	February 6
William G. McCreight, Sr., MD	March 10

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Orthopaedic & Reconstructive Research Foundation - Oklahoma City

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Saint Francis Hospital - Tulsa

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Valley View Hospital - Ada

Duncan Regional Hospital - Amy Wade - 580-251-8648

April 13	"Osteoporosis"	Noon	1 hour
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April 01	Mental Health: "Pain Management-Treating the Whole Person"	8:30am	3 hours
April 7,21,28	Tumor Board	7:00am	1 hour
April 10	Med. Dept.: "Treatment of Atrial Fibrillation"	7:00am	1 hour
April 11	Pediatrie Dept.: "Is ADD/ADHD the Only Problem"	7:00am	1 hour
April 14	Cancer Conferenee: TBA	7:00am	1 hour
April 18	Family Practice Dept.: "Rethinking I.B.S"	7:00am	1 hour
April 18	Ophthalmology: TBA	Noon	1 hour
April 21	OB/GYN Dept.: "Multiple Gestation: Antepartum Care & Intrapartum Management"	7:00am	1 hour

Mercy Health Center - Debbie Stanilla - 405-752-3806

April 04	Interdisciplinary Breast Conferenee	7:00am	1 hour
April 06	"Gaps in the End-of-Life Care"	12:15pm	1 hour
April 11	Neuroseienee Inst. Leeture Series	7:00am	1 hour
April 13	"Helieobaeter Pylori"	12:15pm	1 hour
April 19	Ethies for Luneh-"Palliative Care"	Noon	1 hour
April 20	"Lumbar Spine Disorders"	12:15pm	1 hour
April 27	"Management of Chronie Joint Pain"	12:15pm	1 hour

St. Anthony - Sandy Coury - 405-272-0411

April 03	"End of Life Care"	8:00am	1 hour
April 06	Caneer Inst. Case Presentation-TBA	7:00am	1 hour
April 10	Heart Conf. Presentation-TBA	8:00am	1 hour
April 13	"The Role of Tamoxifen in the Treatment of Breast Caneer"	7:00am	1 hour
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April 18	"Minimally Invasive Cardiae Techniques"		1 hour
April 20	"Brain Death"		1 hour
April 25	Case Review		1 hour
April 27	"Neuroleptie Malignant Syndrome"		1 hour
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THE LAST WORD

Surgeon General to Speak at Annual Meeting



Dr. David Satcher, Assistant Secretary for Health and US Surgeon General, will be the keynote speaker for the Presidents' Inaugural to be held at 7 pm Friday, May 5, at the National Cowboy Hall of Fame in Oklahoma City.

Dr. Satcher is the 16th Surgeon General of the United States. Sworn in on February 13, 1998, he is only the second person in history to simultaneously hold the positions of Surgeon General and Assistant Secretary for Health. In these roles, he serves as the Secretary's senior advisor on public health matters and as Director of the Office of Public Health and Science.

Prior to his nominating Dr. Satcher to serve in his present post, President Clinton had appointed him as Director of the Centers for Disease Control and Prevention and Administrator of the Agency for Toxic Substances and Disease Registry, where he served from 1993 to 1998. Before joining the Administration, he was President of Meharry Medical College in Nashville, Tennessee, from 1982 to 1993.

Dr. Satcher served as professor and chair of the Department of Community Medicine and Family Practice at Morehouse School of Medicine from 1979 to 1982. He is a former faculty member of the UCLA School of Medicine and Public Health and the King-Drew Medical Center in Los Angeles, where he developed and chaired the King-Drew Department of Family Medicine. From 1977 to 1979, he served as interim dean of the Charles R. Drew Postgraduate Medical School, during which time he negotiated the agreement with UCLA School of Medicine and the Board of Regents that led to a medical education program at King-Drew. He also directed the King-Drew Sickle Cell Research Center for six years.

Dr. Satcher is a former Robert Wood Johnson Clinical Scholar and Macy Faculty Fellow. He is the recipient of 18 honorary degrees and numerous distinguished honors, including top awards from the American Medical Association, the American College of Physicians, the American Academy of Family Physicians, and Ebony magazine. In 1995, he received the Breslow Award in Public Health and in 1997 the New York Academy of Medicine Lifetime Achievement Award. Earlier this year, he received the Bennie Mays Trailblazer Award and the Jimmy and Roslyn Carter Award for Humanitarian Contributions to the Health of Humankind from the National Foundation for Infectious Diseases.

Dr. Satcher graduated from Morehouse College in Atlanta in 1963 and was elected to Phi Beta Kappa. He received his MD and PhD from Case Western Reserve University in 1970 with election to Alpha Omega Alpha Honor Society. He did residency/fellowship training at Strong Memorial Hospital, University of Rochester, UCLA, and King-Drew. He is a fellow of the American Academy of Family Physicians, the American College of Preventive Medicine, and the American College of Physicians.

Dr. Satcher would most like to be known as the Surgeon General who listens to the American people and who responds with effective programs. His mission is to make public health work for all groups in this nation. He not only is a champion of promoting healthy lifestyles, he is also an avid jogger and enjoys tennis, gardening, and reading.

Born in Anniston, Alabama, on March 2, 1941, Dr. Satcher and his wife, Nola, reside in Bethesda, Maryland and have four grown children.

For information regarding the Annual Meeting, contact Barbara Matthews or Michele Smith at (405) 843-9571 or (800) 522-9452.

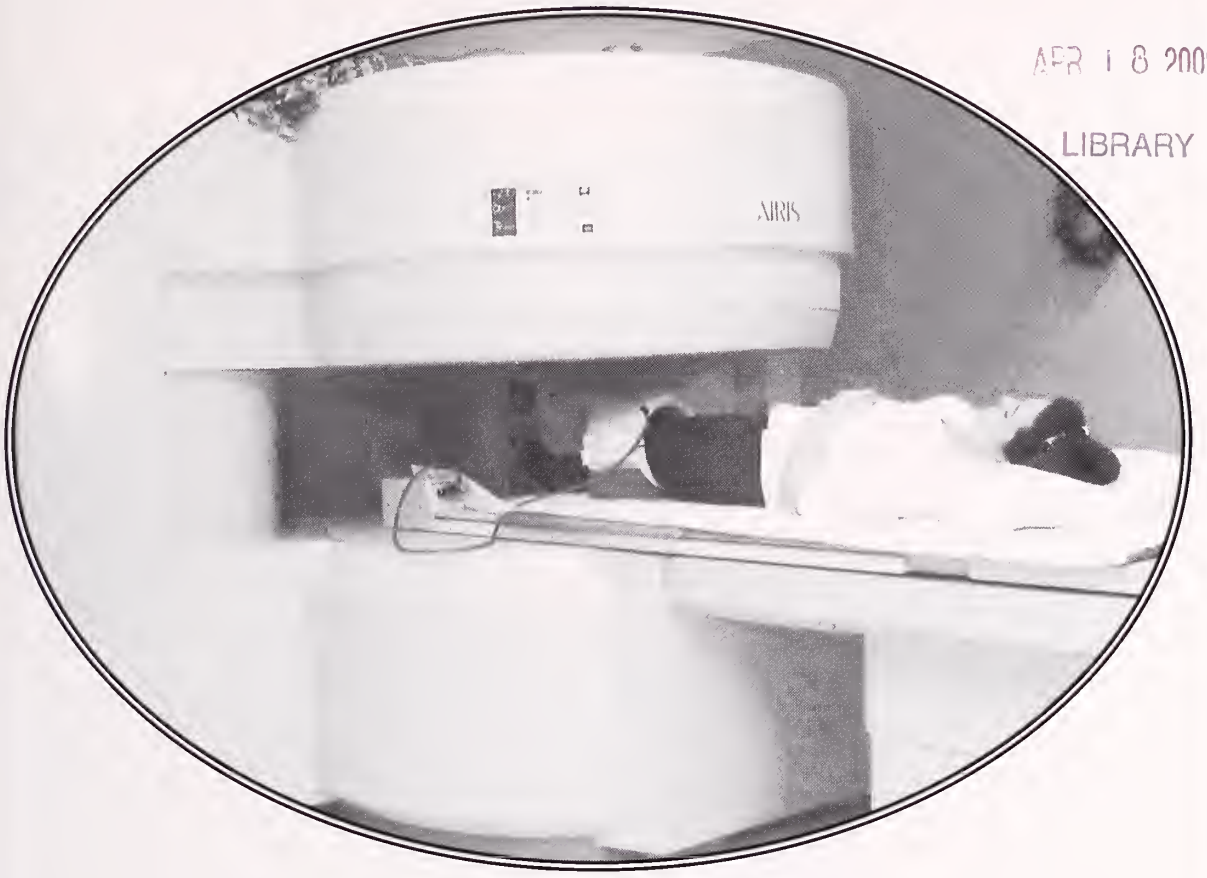
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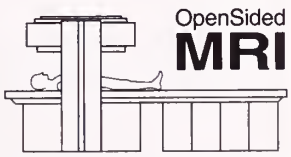
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NSIDE:

Bioterrorism
187

Gestational Diabetes
197

Smoking Cessation
203

News
212



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OKLAHOMA STATE MEDICAL ASSOCIATION

MAY 2000 VOL. 93, NO. 5

EDITORIAL
Awakenings 183
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE
Meeting the Challenge 185
ROBERT J. WEEDN, MD, DUNCAN

EDUCATION
Medical Response to Bioterrorism: Are We Prepared? 187
JOE D. HAINES, MD, PERKINS; KEN PITTS, PA-C, OKLAHOMA CITY; JAMES M. CRUTCHER, MD, MPH, OKLAHOMA CITY

SCIENTIFIC
Screening for Gestational Diabetes: An Evidence-Based Approach 197
NEAL D. CLEMENSON, MD, OKLAHOMA CITY

SPECIAL
Smoking Cessation Overview 203
SHAWN K. LEE, MD, OKLAHOMA CITY; DAVID C. LEVIN, MD, OKLAHOMA CITY; ROBERT MCCAFFREE, MD, OKLAHOMA CITY

DOCTOR'S DIARY
Violence in Perspective 210
JOE D. HAINES, JR., MD, PERKINS

NEWS
Oklahoma Physician Promoted to Brigadier General, 212...Oklahoma Physicians Recognized for Contributions to Mental Health, 212...Oklahoma Scientists Conducting Groundbreaking Research on Alzheimer's Disease, 212...OSMA Medicine Day, 213...Dextromethorphan Abuse on the Rise in Oklahoma, 214

DEPARTMENTS
From the Oklahoma State Department of Health, 215...Obituaries, 217...In Memoriam, 217...Letters to the Editor, 218...CME, 219...Alliance, 223...The Last Word, 224

ABOUT THE COVER

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Awakening...



I often awaken between three and four in the morning.

I am not sure what motivates this behavior, but it happens nonetheless. Wide awake, I do my best thinking while trying to find sleep's elusive dreams again.

Over the years I have shared my story of "early morning thinking" with patients. Every once in awhile, a patient will present me with a clinical problem for which I don't have a clue. I will send them on to a consultant...and then wake up at 3 AM with the answer. I have never been so bold as to call them up and share my answer, but I do keep a scrap of paper by the nightstand so that I can jot down a note or two.

When I am troubled, the frequency of my awakening increases.

I have been waking up in the early morning for some time now. The recurrent theme has been how to get a grip on access to health care in this country. In some ways it haunts me. In other ways I look forward to my "awakenings," hoping that the answer will be plopped down in my 3 AM meandering.

I know—you think that I am going to give you some epistle from heaven. As you read this, you begin to become uncomfortable about another "crazy idea" that invaded the *Journal* editor's head, who is getting ready to espouse "truth."

I am afraid that I don't have the answer, but I am full of questions and concerns.

We live in a time when 20% of Oklahomans do not have adequate health care coverage. Multiple reasons, multiple causes...you face them in your practice on a daily basis. Two or three part time jobs, none with benefits. Lack of insight into the importance of health care coverage. Lack of motivation or just plain stupidity...the list is long.

As physicians, we are in an awkward position when the problem of health care access is addressed. Most of us are busy—many of us believe that we are much too busy—taking care of the paperwork involved in our profession. Then there is the problem of worrying what new change will be placed in our path, and what effect that change will have on our ability to provide appropriate care to our patients.

We fatigue from the multiple changes that confront us to the point that we entrench ourselves and resist any change. It is our nature. For some it is a calling, for others it is the path of least resistance. Meanwhile, Oklahoma's health care access continues to be impaired.

Our mindset has become, "We have ours, let them get theirs."

I volunteer at our local community clinic. Open for two hours, once a week, with a different doctor each week. People start lining up at 1 PM for a 6 PM visit with the physician. The service is free, volunteered by members of our medical society and other interested community members. The clinic is free, but woefully inadequate in terms of quality primary care. Although this approach may decrease the number of folks in the ER on that specific night, these patients go on to develop progressive chronic health problems.

As I sit in my comfortable practice on the comfortable side of town, I fail to see the lines outside the Community Clinic. My failure to see them does not make the lines go away. My failure to see the big picture does not fix the problem...it only adds to the complacency...it only prolongs the problem.

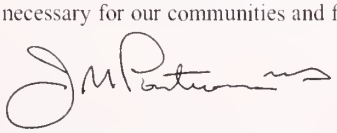
My "awakenings" have also made me cynical about the answer coming from other segments of our culture. The medical-industrial complex has much invested in the current arrangement of insurance-based health care. It is much easier to lobby for increased compensation than it is to significantly redesign the system. To allow the insurance companies to design the answer is naïve and misdirected. To wait until the government designs an answer is fraught with treachery as well. From my perspective, I am not sure either group will do what is needed—one motivated by profit, the other by political pressure.

And so we sit here.

At what point will health care reform be forced upon each of us? When Oklahoma's uninsured population is at 25%, or it is 37.5%? Are we destined to passively wait until the crisis explodes? I am sure that we will discuss with each other the fact that we can't understand why "they" are doing this "to" us.

My opinion...we are "doing" it to ourselves through our inability to design a legitimate alternative.

Is it too intimidating to join me in the "awakening"? Trust me, 3 AM has many answers. We just have to be able to put them down in some coherent manner. It is necessary for our communities and for our profession.



J. Michael Pontious, MD
Editor-in-Chief

"At what point will health care reform be forced upon each of us? When Oklahoma's uninsured population is at 25%, or it is 37.5%? Are we destined to passively wait until the crisis explodes?"

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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Meeting the Challenge

It is an honor and a privilege to serve as your new President—just as it is an honor and a privilege to be a member of this noble profession. I accept this position of leadership with pride but also with great humility. I feel a strong sense of responsibility as we are confronted with many challenges from outside and inside our profession and our professional organizations—in particular, the Oklahoma State Medical Association. Challenges, however, provide opportunities to solve problems and offer solutions together. Our potential for success will, ultimately, be determined by our ability to work together for the benefit of our patients, our profession, our colleagues, and ourselves.



I believe that the Physicians' Campaign for a Healthier Oklahoma provides us with a real opportunity to meet the challenging, substantial health problems faced by Oklahomans as so clearly documented in the *State of the State's Health Report* produced by the Oklahoma State Board of Health and State Health Department. Certainly, we have no control over underlying economic reasons that the health status of Oklahomans has progressively declined in the last decade, especially in comparison to national trends.

We can, as individual physicians and as an organization, however, be a significant part of the solution because most of these health problems are preventable and are lifestyle-related. We are in a unique position to lead a statewide comprehensive effort to address this part of the problem.

Toward this end, your 1999 OSMA House of Delegates endorsed and approved the concept of a task force to develop the Physicians' Campaign for a Healthier Oklahoma (PCHO). The PCHO mission is as follows: *"To improve the health of the people of Oklahoma by changing lifestyles and behavior."*

A comprehensive plan has been developed, goals defined, priorities delineated, scope determined, and implementation objectives outlined. The details of this plan were reported in the January issue of the OSMA *Journal*. The plan has also been presented by myself and members of the task force at a number of county medical society meetings, and more such presentations are pending.

The priorities for the PCHO plan are *education*, *prevention*, and *coalition building*. The scope of the campaign is three-tiered: in the physician's office; in the community in conjunction with the county medical society and its Alliance; and on a statewide level through the OSMA/OSMAA.

The most important implementation objective in the physician's office is the promotion of clinical prevention and wellness through patient education regarding healthy lifestyles. You have already received patient lifestyle assessment and education pamphlet samples and poster information in a letter from me in April. These tools for your practice will be helpful only if you use them.

The most important county medical society implementation objective is to develop lifestyle and wellness education projects and programs through a joint effort of those societies, their Alliances, local health departments, schools, the faith community, private businesses, and local civic organizations. A great example of this sort of project is the Oklahoma County Medical Society's "Schools for Healthy Lifestyles." This type of effort can only happen if you and your county medical society take the initiative and become involved.

On a statewide basis, the OSMA is publishing monthly *Journal* articles that include patient handouts that can be reproduced and given to patients in your office. Additionally, a statewide radio campaign—known as the Oklahoma Health News Network—is just now starting and will provide free health tips (including many recorded by OSMA physicians) for radio stations throughout

"Ultimately, however, the responsibility comes back to you and me. We must make a concerted effort to teach as well as treat...to prevent as well as heal...and to practice what we preach and/or teach."

the state. A limited TV campaign may be added, as funds are available. Additional programs such as the Take Care campaign and EMS file vials, the Extinguisher anti-smoking effort targeted at grade school-aged children, and other media interviews and events are planned to promote healthy lifestyles, the PCHO, and your involvement in it. Of particular note is the fact that the same educational and informational tools are being made available for use in state and county health department clinics throughout Oklahoma by the State Health Department, our major partner in this project.

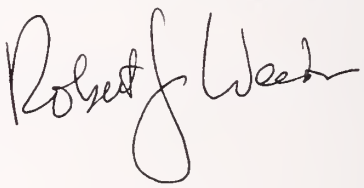
Ultimately, however, the responsibility comes back to you and me. We must make a concerted effort to teach as well as treat . . . to prevent as well as heal . . . and to practice what we preach and/or teach.

There are myriad choices for people in this cosmopolitan, high-tech, information-filled world. Frequently, the best choices are the simplest but not necessarily the most obvious. We can have a substantial impact by showing our personal concern for the patient and by counseling him or her regarding their lifestyle choices. In so doing, we will have the opportunity to not only improve the health of Oklahomans but also to send a clear—accurate—message to the public about who we really are and what we stand for.

This initial year's PCHO effort, funded by your dues dollars and supplemented by State Health Department matching funds, is designed to prime the pump, so to speak. If we can demonstrate substantial participation by physicians in this project—one that no other state medical association has ever undertaken—then there is a real possibility of obtaining future funding for the PCHO through the development of a permanent endowment and public and private grants.

I urge you to join the Physicians' Campaign for a Healthier Oklahoma. We are stronger as a whole than we are separately, and we can have a greater impact working together than we could ever dream of individually if we *work in unison* and *act now* while we have some momentum on our side. It's the right thing to do, and it's good medicine.

Thank you for your confidence and your support. You have my pledge that I will spend the next year working for our OSMA with honesty and integrity, seeking input from all, trying to the best of my ability to serve all of you, and seeing that the OSMA serves its members in a fiscally responsible manner as we move into the 21st Century. I look forward to visiting with you on these pages in the coming months. Meanwhile . . . ***I wish you well.***



Robert J. Weedn, MD
OSMA President

Medical Response to Bioterrorism: Are We Prepared?

Joe D. Haines, MD; Ken Pitts, PA-C; James M. Crutcher, MD, MPH

The 1995 bombing of the Federal Building in Oklahoma City made terrorism a shocking reality for all Oklahomans. The fact that such an event could happen here, far from foreign political and ethnic conflicts and from large coastal cities, made us realize that no one is immune from the terrorist threat. But as horrific as that event and other terrorist incidents have been, the present threat of the use of infectious agents in acts of terrorism has the potential to cause far greater human death and suffering than any previously used terrorist weapon.

Although health care professionals have not historically participated in terrorist planning and response activities, the addition of infectious agents to the terrorists' arsenal makes medical and public health professionals critical players in these efforts. Indeed, physicians have the ability to first recognize and report such an event and thereby diminish the impact.

To meet the bioterrorism responsibility, physicians must be knowledgeable of this type of threat. In this article we present an overview of bioterrorism and review the organisms most likely to be used in a terrorist event.

Introduction

It is 2:30 p.m. on an October Saturday in Dallas, Texas. One of the greatest rivalries in college football, the OU-Texas game, is about to kick off. The game is sold out, as it has been every year since 1946. Over 75,000 fans eagerly await the contest. The day is cool, calm, and clear—perfect football weather. Outside the Cotton Bowl, many thousands of additional visitors have turned out for the Texas State Fair.

As the game gets underway, a crop-duster takes off from a nearby airfield and within minutes is directly over the Cotton Bowl and the fairgrounds. Most people ignore the plane as it circles lazily overhead. On its second pass, the crop-duster releases 100 kilograms of fine powder that disperses in a cloud over the stadium. The substance is odorless and invisible as it settles into the stadium and surrounding fairgrounds. Tens of thousands of people inhale the microscopic particles released from the plane.

By the following Monday morning, phone lines to doctors' offices in Oklahoma and Texas are jammed with calls of patients complaining of "flu" symptoms. Emergency rooms are also suddenly seeing an increase in people with severe respiratory complaints and flu-like illnesses. Victims complain of a range of symptoms, including fever, dyspnea, cough, headache, vomiting, chills, weakness, abdominal pain, and chest pain. Physical signs and lab studies are nonspecific. Most of these patients are treated symptomatically and released with a diagnosis of flu. Some patients have an apparent recovery over the next few days.

Other patients, however, progress abruptly to worsening fevers, dyspnea, diaphoresis, and shock. Emergency rooms notice that chest x-rays of the victims all have a widened mediastinum. Gram stains of blood show gram positive bacilli on unstained smears. Three days following the OU-Texas game, emergency rooms are seeing many patients in acute respiratory distress. All ventilators and ICU beds are quickly filled. Many victims who were evaluated over the previous two days suddenly die.

Within three days of the onset of symptoms, over half of the persons affected by this illness are dead. Four days following exposure, a terrorist organization announces responsibility for releasing anthrax spores from the crop-duster. Blood culture results from the Centers for Disease Control reveal the presence of a gram positive bacillus, identified as *Bacillus anthracis*.

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Victims in a three kilometer radius of the stadium are infected. An acute shortage of hospital beds, ventilators, antibiotics (over 10,000 pounds are required), and vaccine result in many more deaths.

The Threat of Bioterrorism

While this terrifying scenario may sound like a plot for a techno-thriller, the sobering truth is that a major bioterrorist attack in the United States is likely to occur in the next five years.[1,2] The only questions that remain are where, when, and what bioterrorist agent will be employed. Secretary of Defense William Cohen has remarked that a bioterrorist attack on the United States "is not a remote possibility but a real probability in the present. Imagine the horror." In a November 1997 report, Cohen singled out Libya, Iraq, Iran, and Syria as countries "aggressively seeking" nuclear, biological, and chemical weapons. And the threat is not limited to foreign countries, but also exists from groups within our own borders. Consider the following recent events as evidence that terrorist groups perceive biological agents as viable options:

1) In 1972, an American fascist group, the Order of the Rising Sun, used 30 to 40 kg of *Salmonella typhi* (typhoid fever) to contaminate the Chicago and St. Louis water supplies. Fortunately, the attempt was not successful in causing illness.

2) In 1984, the Red Army Faction allegedly tried to use botulinum toxin in Paris.

3) In 1986, over 700 people became ill in Oregon when the Bhagwan Cult poisoned salad bars with *Salmonella* bacteria.[3]

4) In 1995, a member of the Aryan Nation was arrested for ordering plague from a Maryland supply house. Two members of the Minnesota Patriots Council were also convicted for planning to use ricin in an assassination attempt.

On the chemical warfare front, in 1985 the Covenant Group in Arkansas was discovered to have 33 gallons of cyanide in their possession. In 1992, German police prevented the release of cyanide in a synagogue by Neo-Nazis. In 1994 and 1995, sarin was used by the Aum Shinrikya, killing seven and injuring 280 in Matsumoto, Japan, and killing twelve and injuring 5,500 in a second attack in a Tokyo subway.[4]

Copycat attacks sprung up in Japan using cyanide, phosgene, and pepper spray. The FBI thwarted a possible sarin attack at Disneyland shortly thereafter. In 1997, two chlorine bombs were activated in a Sydney, Australia shopping mall, injuring 14. Add to these events the campaign of bombings in the nineties, the worst being the Oklahoma City bombing killing 168, and the 62 documented cases of nuclear smuggling worldwide, and the potential for disaster seems high indeed.

History

Even though biowarfare is often considered to be a "modern" addition to the means of waging war, it has actually been practiced since the sixth century B.C. The Assyrians poisoned enemy wells with rye ergot, and Solon used the purgative herb hellebore against his enemies during the siege of Krissa. In 1346, plague broke out in the Tartar army during the siege of Kaffa (in present day Crimea) and the attackers hurled corpses of the victims over the city walls. The plague epidemic that followed forced the defenders to surrender. The Russians reportedly used the same plague-infested corpse technique against the Swedes in 1710.

Smallpox was used as a biological weapon by Pizzaro when he presented South American natives variola-contaminated clothing in the fifteenth century. The English did the same when Sir Jeffrey Amherst provided Indians loyal to the French with smallpox-laden blankets during the French and Indian Wars of 1754-1767.

During the American Civil War, Dr. Luke Blackburn was accused of participating in a plot to introduce yellow fever into northern cities. Clothing worn by yellow fever victims was shipped north in the mistaken attempt to spread the disease. Three shirts were even specially prepared to send to Abraham Lincoln, but never delivered. It was not until 1900 that Walter Reed and other physicians discovered that yellow fever was transmitted by the mosquito.

In the 20th century, German agents inoculated horses and cattle with glanders before the animals were shipped to France during World War I. In 1937, Japan began an ambitious biowarfare program called Unit 731. Following World War II, investigators revealed that the Japanese government experimented on prisoners of war. Approximately 1,000 autopsies were performed at Unit 731, mostly on victims infected with aerosolized anthrax. Some have estimated that up to 3,000 prisoners were killed. By 1945, the Japanese had stockpiled 400 kilograms of anthrax to be used in specially designed fragmentation bombs.

The United States began research into biowarfare in 1943 due to a perceived German threat. President Nixon ordered production of

biowarfare agents stopped in 1969. By 1972, all stockpiles of American biological agents and munitions were destroyed. In 1972, the United States and many other countries signed the Convention on Prohibition of the Development, Production and Stockpiling of Bacteriologic (Biological) and Toxin Weapons and Their Destruction.

Despite this agreement, several countries, such as Iraq and the former Soviet Union, continued to produce and perform experiments in biowarfare. In late April of 1979, an incident occurred in Sverdlovsk in the former Soviet Union due to the accidental release of anthrax in aerosolized form from a Soviet military biowarfare facility. Residents living downwind from the facility were exposed, resulting in 79 cases of anthrax and 68 deaths. Following the Gulf War in 1991, it was discovered that Iraq possessed 19,000 liters of botulinum toxin, 8,500 liters of anthrax, and 2,200 liters of aflatoxin. Large amounts of these agents had been filled into weapons and deployed for apparent potential use.

Medical Provider Response to Biowarfare

The threat of bioterrorism presents the medical and public health community with a myriad of challenges. Response efforts will vary depending upon the different scenarios in which a bioterrorism event may occur. These may vary from an instantaneous event, such as an explosion or large-scale use of an agent in a public place (such as the anthrax scenario presented previously), to the clandestine distribution of an agent on a small scale. In both cases, medical professionals play a critical role. In the first scenario, they must be able to respond rapidly to a crisis situation in which hundreds, perhaps thousands, of persons become severely ill in a short period of time. In the latter scenario, physicians serve as the front-line surveillance system. Since they are the first to see patients with possible bioterrorism-related illnesses, they have the ability to first recognize and report such an event so that it may be rapidly investigated and, hopefully, its impact diminished.

It is therefore critical that physicians be knowledgeable of the bioterrorism threat and how to respond. The physician must be alert for unusual occurrences of disease that may indicate a possible bioterrorist event (Table 1). Once we have been alerted to such an event, response efforts will depend upon which agent is used, the manner in which it is deployed, and the point in time at which its use is confirmed or suspected. Vaccines for primary prevention of disease are available for several of the possible bioterrorist agents. Anthrax vaccine is currently the only one of these in widespread use (and presently only by the military), but others may follow. Of particular concern is the possible use of smallpox by terrorist groups, which could result in the need to resume smallpox vaccine production and use. Following a known or suspected exposure, active or passive immunization and/or prophylactic treatment with antibiotics may prevent or ameliorate disease. After onset of illness, rapid diagnosis and treatment are crucial to decrease mortality.

Table 1. Indications of a Possible Bioterrorist Event

1. Large numbers of ill persons with a similar disease or syndrome.
2. Increase in cases of unexplained diseases or deaths.
3. Illness that is unusual for a given population or age group.
4. Higher morbidity or mortality in association with a common disease, or failure of such patients to respond to usual therapy.
5. Illness caused by an agent not endemic to area.
6. Unusual seasonal distribution of illness.
7. Stable endemic disease with an unexplained increase in incidence.
8. Simultaneous clusters of similar illness in noncontiguous areas.
9. Atypical transmission of disease through aerosols, food, or water, which suggests deliberate sabotage.
10. Unusual illness among animals that precedes or accompanies illness in humans.

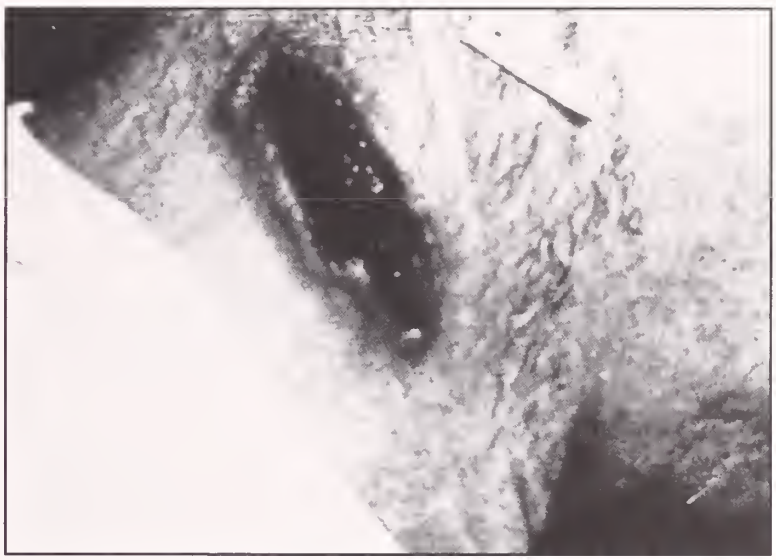


Figure 1. Black eschar of cutaneous anthrax; lesion on neck at approximately day 15 of disease. (Reprinted with permission from Textbook of Military Medicine, Medical Aspects of Chemical and Biological Warfare, Walter Reed Army Medical Center, Washington D.C., 1997)

Table 2. Summary of Biological Warfare Agents

Agent	Infective Dose (aerosol)	Incubation Period	Diagnostic Sample/ Biosafety Level	Diagnostic Assay	Patient Isolation Precautions
Anthrax	8,000 to 50,000 spores	1-5 days	Blood/BSL-2	Gram's Stain, Ag-ELISA. Serology: ELISA	Standard precautions
Brucellasis	10-100 org	5-60+ days (occasionally months)	Blood, bone marrow. Acute and convalescent sera/BSL-3	Serology: agglutination	Standard precautions
				Culture	Contact isolation if draining lesions present
Plague	100-500 org	1-3 days	Blood, sputum, lymph node ospirote/BSL-2/3	Grams's or Wright-Giemsa Stain, Ag-ELISA, Culture, Serology: ELISA IFA	Pneumonic: Droplet precautions until patient treated for 3 days
Q Fever	1-10 org	10-40 days	Serum/BSL-2/3	Serology: IFA, ELISA	Standard precautions
Tularemia	10-50 org	2-10 days	Blood, sputum, serum EM of tissue/BSL-2/3	Culture, Serology: Agglutination	Standard precautions
Smallpox	Assumed low (10-100 org)	7-17 days	Pharyngeal swab scab material/BSL-4	ELISA, PCR Virus isolation	Airborne precautions
Viral Encephalidities	10-100 org	VEE 2-6 days EEE/WEE 7-14 days	Serum/VEE, BSL-3 EEE & WEE BSL-2	Viral isolation, Serology: HI ELIZA	Standard precautions (mosquito control)
Viral Hemarrhagic Fevers	1-10 org	+21 days	Serum/blood most are BSL-4; RVF, KHF, and YF are BSL-3	Viral isolation, Ag-ELISA, RT-PCR Serology: Ab-ELISA	Contact precautions Consider additional precautions if massive hemorrhage
Batulinum	0.001 ug/kg (Type A)	1-5 days	Nasal swab (possibly)/ BSL-2	Ag-ELISA, Mouse neut.	Standard precautions
Staphylacaccal Enterataxin B	30 ng/person (incap.) 1.7 ug/person (lethal)	1-6 hr	Nasal swab, serum, urine/BSL-2	Ag-ELISA, Serology: Ab-ELISA	Standard precautions

- Information on diagnostic, medical management, and vaccines is available by contacting Commander, USAMRIID, at 301-619-2833 (Phone) or 301-619-4625 (FAX)
- Note Consult product literature before administering drugs or vaccines.

In the remainder of this article we provide a brief overview of the "top ten" agents in the bioterrorists' arsenal. The agents which present the greatest potential threat include anthrax, smallpox, plague, brucellosis, tularemia, Q fever, viral encephalitides, viral hemorrhagic fevers, botulism, and staphylococcal enterotoxin B. Table 2 summarizes information concerning diagnosis, medical management, and vaccines for these agents. Several articles have been published recently which provide a more detailed review of some of these diseases.[5-11]

Anthrax

Few biological warfare agents have received as much attention in the popular media as *Bacillus Anthracis*, and for good cause. Anthrax would most likely be released by terrorists in an aerosolized cloud, resulting in the inhalational form of the disease. Unfortunately, almost all cases of inhalational anthrax in which treatment is begun after patients become symptomatic are fatal, regardless of treatment. It is estimated that 50 kilograms of aerosolized *B.anthracis* spores, dispensed by an aircraft two kilometers upwind of a population center of 500,000 unprotected people, would travel 20 kilometers downwind and kill up to half of the people in the path of the biological cloud.

Signs and Symptoms: The incubation period from an inhalational challenge varies from one to six days (dose dependent). Initially, fever, malaise, and fatigue, along with a non-productive cough, may be present. Symptoms progress to severe respiratory distress with dyspnea diaphoresis, stridor, and cyanosis. Shock and death usually follow one to three days after pulmonary symptoms become severe. Cutaneous anthrax follows dermal inoculation of the organism. The lesion begins as a papule, then progresses to a vesicle, and finally a depressed black eschar (Figure 1). The eschar is usually

Table 2. Summary of Biological Warfare Agents (continued)

Agent	Chemotherapy (Rx)	Chemoprophylaxis (Px)	Vaccine Availability	Comments
Anthrax	Ciprofloxocin 400 mg iv q 8-12 hr	Ciprofloxocin 500 mg bid x 4 wk If unvoccinoted, begin initiol 3 doses of voccine	Mich Bro Prod Inst voccine (licensed): 0.5 ml @ 0,2,4 wk, 6, 12, 18 mo.	Boost ot-risk onnuolly
	Doxycycline 200 mg. iv, then 100 mg iv q 8-12 hr	Doxycycline 100 mg po bid x 4 wk Plus voccinotion		Alternotes for Rx: gentomincin, erythromycin, ond chloromphenicol
	Penicillin 2 mill units iv q 2 hr + streptomycin 30 mg/kg im per doy (or gentomicin)			For penicillin sensitive orgonisms
Brucellosis	Doxycycline 200 mg/doy po plus Rifompin 600-900 mg/day po x 6 wk	Doxycycline ond Rifompin for 3 wk in inodvertently inoculoted persons	No voccine ovoilable for humon use	Trimethoprin-sulfomethoxozole moy be substituted for Rifompin, however, relopse rote with this drug moy be up to 30%
Plague	Streptomycin 30 mg/kg im in divided dose x 10 doys (or Gentamicin)	Tetrocyline 500 mg po qid x 7 doys	Greer inoctivated voccine (licensed): 1.0 ml then 0.2 ml boost ot 1-3 ond 3-6 mo	Boost ot-risk 12, 18 months & yeorly. Plogue voccine not protective V's oerosol in onimol studies Alternote Rx: chloromphenicol Alternote: trimethoprim-sulfomethoxozole Rx: plogue meningitis
	Doxycycline 200 mg iv then 100 mg iv q 12 hr x 10-14 doys	Doxycycline 100 mg po q 12 hr x 7		
	Chloromphenicol 1 gm iv q 6 hr x 10-14 doys			
Q Fever	Tetrocycline 500 mg po q 6 hr x 5-7 doys	Tetrocyline Stort 8-12 doys postexposure x 5 doys	IND 610 Inactivated Whole Cell Vaccine given os single 0.5 ml sc	Recommended skin test before voccinotion
	Doxycycline 100 mg po q 12 hr x 5-7 doys	Doxycycline Stort 8-12 doys postexposure x 5 doys		
Tularemia	Streptomycin 30 mg/kg im per doy x 10-14 doys	Doxycycline 100 mg po q 12 hr x 14 doys	Live ottenuoted voccine (IND): scorificotion	Culture difficult ond potentiolly dongerous
	Gentomicin 3-5 mg/kg/doy x 10-14 doys	Tetrocycline 2 gm/day po x 14 doys		
Smollpox	Cidofovir effective in vitro	Voccinio immune globulin (VIG) 0.6 ml/kg im (within 3 doys of exposure; best within 24 hr	Wyeth Colf Lymph Voccinio voccine (licensed) ond DoD cell-culture derived Voccinio voccine (IND): scorificotion	Pre- ond postexposure voccination recommendotion if > 3 yeors since lost voccinotion
Virol Encepholidities	Supportive theropy, onolgesics, onticonvulsonts os needed	N/A	VEE DoD TC-83 Live Attenuoted Voccine (IND): 0.5 ml sc x 1 dose VEE DoD C-84 (Formolin Inoctivoted TC-83) (IND): 0.5 ml sc for up to 3 doses EEE inoctivoted (IND): 0.5 ml sc ot 0 & 28 doys - WEE inoctivoted (IND): 0.5 ml sc ot 0, 7, & 28 doys	Reoctogenic in 20% No seroconversion in 20% Only effective vs. IA/B ond IC Voccine used for non-responders to TC-83 Poorly immunogenic Multiple immunizotions required
Virol Hemorrhagic Fevers	Supportive theropy, Ribovirin (CCHF/Arenoviruses) 30 mg/kg iv 15 mg/kg iv q 6 hr x 4 doys 7.5 mg/kg iv q 8 hr x 7 doys	N/A	Argentine HF Condid #1 voccine (x-protection for Bolivion HF) (IND)	Aggressive monogement of secondory infections ond hypotension is importont
			Rift VF, inoctivoted voccine (IND)	
Botulinum	DoD heptovolent ontioxident (A-F) (IND): equine despecioted 1 viol (10 cc) iv	N/A	DoD Pentovolent (A-E) Toxoid (IND): sc @ 0, 2 & 12 wk, then yeorly boosters	Skin testing for hypersensitivity before equine ontioxin administration
	CDC Trivolent equine ontitoxin (AB & E) (Licensed)			Ventilotory ossistonce
Stophylococcal Enterotoxin B	Ventilotory support ond supportive core	N/A	No voccine ovoiloble	Vomiting ond diorrheo moy occur if toxin is swollowed

- Information on diagnostic, medical management, and vaccines is available by contracting Commander, USAMRIID, at 301-619-2833 (Phone) or 301-619-4625 (FAX)
- Note: Consult product literature before administering drugs or vaccines.



Figure 2. Pulmanary anthrax, day 2 af illness in a 51-year-old man. Marked mediastinal widening is evident, with a small porenchymal infiltrate. (Reprinted with permissian fram Textbook of Military Medicine, Medical Aspects af Chemical ond Biolagical Warfare, Walter Reed Army Medical Center, Woshingtan D.C., 1997)

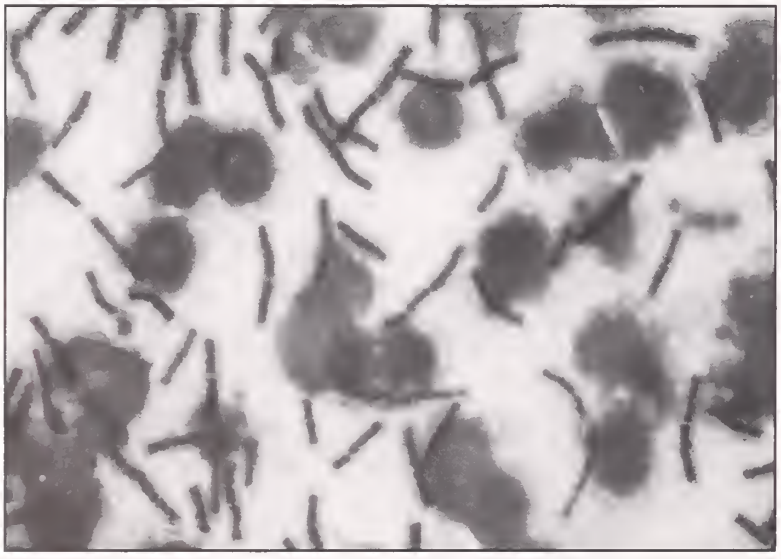


Figure 3. Gram stoin af peripheral blood fram o rhesus mankey that died af inhalatian anthrax. (Reprinted with permission from Textbaak af Military Medicine, Medical Aspects af Chemical and Biolagical Worfare, Walter Reed Army Medical Center, Washingtan D.C., 1997)

surrounded by significant edema.

Diagnosis: Physical findings of pulmonary anthrax are usually non-specific. The chest x-ray may reveal a widened mediastinum with pleural effusions (Figure 2). Detection of *B.anthracis* by gram stain of blood (Figure 3) and on blood culture may not be diagnostic until late in the course of the illness.

Treatment: Although usually not effective after symptoms are present, high dose antibiotic treatment with penicillin, ciprofloxacin, or doxycycline should be undertaken.

Prophylaxis: If there is information indicating that a biological attack may have occurred, prophylaxis with ciprofloxacin 500mg PO BID is recommended, to continue for at least 4 weeks in all those exposed. An FDA-licensed vaccine is available. The schedule is 0.5 ml subcutaneously at 0, 2, 4 weeks, then 6, 12, and 18 months for the primary series, followed by annual boosters. The vaccine is currently only available for military forces.

Isolation and Decontamination: Although person-to-person spread of inhalational anthrax is not a threat, secretion and lesion precautions should be practiced. Instruments used in invasive procedures should be disinfected with a sporicidal agent (iodine or chlorine).

Plague

This zoonotic infection is caused by the gram-negative bacillus *Yersinia pestis*. Three great human pandemics have been responsible for more deaths than any other infectious agent in history. The second plague pandemic took the lives of 24 million people between the years 1346 and 1352. The naturally occurring disease in humans is transmitted by a rodent-flea infection cycle with man as an accidental host. This generally results in the form of the disease known as bubonic plague. However, terrorists could theoretically deliver the bacterium in aerosolized liquid droplets, resulting in the highly fatal pneumonic form of the disease.

Signs and Symptoms: The incubation period for bubonic plague ranges from 2 to 10 days, and the patient presents with malaise, high fever, and one or more tender lymph nodes (bubo's). About one quarter of patients with bubonic plague will develop septicemia.

Septicemic plague presents essentially the same as any gram-negative septicemia. Later, purpura, disseminated intravascular coagulation, and acral cyanosis with necrosis may be seen. Pneumonic plague has an incubation period of 2 to 3 days. The presentation is one of malaise, high fever, chills, headache, myalgia, cough with production of a bloody sputum, and toxemia. The terminal event is one of respiratory failure, circulatory collapse, and a bleeding diathesis.

Diagnosis: The chest x-ray reveals a patchy or consolidated bronchopneumonia. A pre-

sumptive diagnosis can be made by microscopic identification of gram-negative coccobacilli with a "safety pin" appearance on Gram or Wayson stain of sputum, lymph node aspirate, or cerebrospinal fluid (Figure 4).

Treatment: Plague pneumonia is almost always fatal if treatment is not initiated within 24 hours of the onset of symptoms. Streptomycin, or alternatively doxycycline, are highly effective in all three forms of plague.

Prophylaxis: Doxycycline 100 mg orally twice daily for 7 days is recommended for known or suspected exposures to respiratorally transmitted plague. Ciprofloxacin is an acceptable alternative.

Isolation: It is extremely important to isolate the patient, both respiratory isolation and secretion precautions, if any form of plague is suspected. Human-to-human transmission of plague can occur from patients with pulmonary infection.

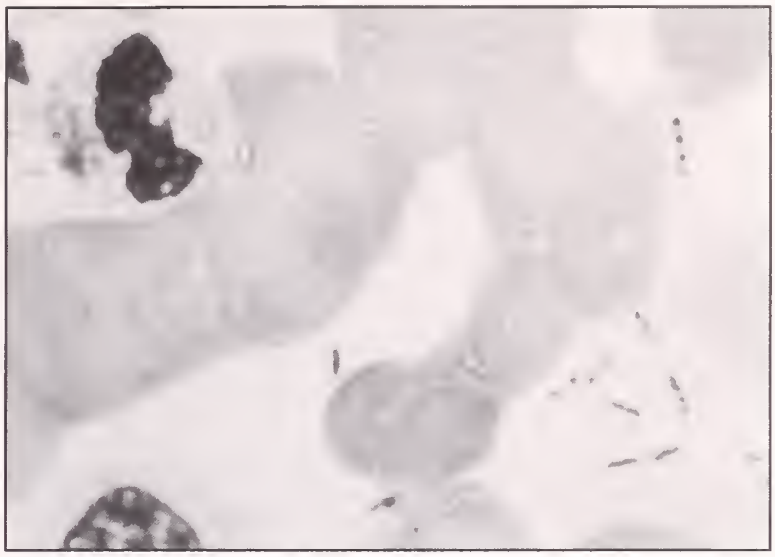


Figure 4. Wright-Giemso stoin of o peripherol blood smeor from o potient with septicemic plogue demonstrotes the bipolor, sofety-pin stoining of Yersinio pestis. (Reprinted with permission from Textbook of Militory Medicine, Medicol Aspects of Chemicol ond Biologicol Worfore, Wolter Reed Army Medicol Center, Woshington D.C., 1997)

Smallpox

The possibility that smallpox could be used in a terrorist event is one of the most frightening of the bioterrorism scenarios. One of the great scourges of humankind, smallpox was declared eradicated in 1980 by the World Health Organization (WHO). Since that time, only two WHO-approved repositories of variola virus remain; one at the Centers for Disease Control and Prevention in Atlanta, and the other at the Institute for Viral Preparations in Moscow. However, the security of the Russian repository is uncertain in the wake of the collapse of the Soviet Union, and it is unknown whether or not clandestine stockpiles now exist in other parts of the world. Moreover, it is felt that the vast majority of persons in the United States at this time are susceptible to the smallpox virus. The United States stopped vaccinating military personnel in 1989 and civilians in the early 1980s. And, since vaccine immunity wanes with time, persons vaccinated prior to that time now have only limited immunity.

Signs and Symptoms: Clinical manifestations begin acutely with malaise, fever, rigors, vomiting, headache, and backache. Skin lesions appear 2 to 3 days later, which quickly progress from macules to papules, and eventually to pustular vesicles. They are more abundant on the extremities and face and develop synchronously.

Diagnosis: Smallpox must be distinguished from other vesicular exanthems, especially chickenpox. The usual method of diagnosis is demonstration of characteristic virions on electron microscopy of vesicular scrapings. Aggregations of virus particles, called Guarnieri bodies, may also be seen with light microscopy. Neither of these methods, however, can distinguish variola from vaccinia, monkeypox, or cowpox. New PCR techniques may be more accurate in discriminating variola from other Orthopoxviruses.

Treatment: At present there is no effective chemotherapy and treatment remains supportive.

Prophylaxis: Immediate vaccination or revaccination should be undertaken for all exposed persons. Vaccinia Immune Globulin (VIG) is of value in post-exposure prophylaxis of smallpox when given within one week of exposure.

Isolation and Decontamination: Droplet and airborne precautions are recommended for a minimum of 17 days following exposure for all contacts. Patients should be considered infectious until all scabs separate.

Tularemia

Francisella Tularensis is very infectious; as few as 10 organisms will cause disease if inhaled or injected intradermally. The infectivity rate is 90% to 100% after exposure to the organism. Similar to anthrax and plague, this organism potentially could be delivered by aerosol in either a wet or dried form, thereby causing a severe pneumonia.

Signs and Symptoms: The ulceroglandular form of tularemia occurs after skin or mucous membrane inoculation with the organism from blood or fluids of infected animals. It may also be acquired from bites from infected deer flies, mosquitoes, or ticks. It begins as a cutaneous ulcer with heaped-up edges at the sight of the inoculation. Swollen, tender lymph nodes proximal to the ulcer almost always occur. Systemic symptoms of malaise, fever, chills, headache, and cough typically follow. Respiratory exposure may cause typhoidal tularemia, with patients presenting with cough, pleuritic chest pain, dyspnea, and possibly hemoptysis.

Diagnosis: Primarily a clinical diagnosis. Identification of the organism by staining ulcer fluid or sputum is generally not helpful. Routine culture is possible but difficult, due to the unusual growth requirements of the bacterium. Chest radiographs will show pneumonia in approximately 50% of patients. The diagnosis can be established retrospectively by serology.

Treatment: Before the availability of effective antibiotics, typhoidal tularemia had a mortality rate of 35%. With appropriate aminoglycoside therapy, the mortality rate has dropped to 1% to 2.5%. Streptomycin is the drug of choice, and gentamicin is probably a reasonable alternative.

Isolation and Decontamination: Secretion and lesion precautions should be practiced. Strict isolation of patients is not required. Organisms are relatively easy to render harmless by heat and disinfectants.

Brucellosis

Signs and Symptoms: Incubation period from 5 to 60 days; average of 1 to 2 months. Acute and subacute brucellosis are non-specific. Irregular fever, headache, profound weakness and fatigue, chills, sweating, arthralgias, mylagias. Depression and mental status changes. Osteoarticular findings (ie, sacroiliitis, vertebral osteomyleitis). Fatalities are uncommon.

Diagnosis: Blood cultures require a prolonged period of incubation in the acute phase. Bone marrow cultures produce a higher yield. Confirmation requires phage-typing, oxidative metabolism, or genotyping procedures. ELISAs followed by Western blotting are used.

Treatment: Doxycycline and rifampin for a minimum of six weeks. Ofloxacin + rifampin is also effective. Therapy with rifampin, a tetracycline, and an aminoglycoside is indicated for infections with complications such as endocarditis of meningoencephalitis.

Prophylaxis: No approved human vaccine is available. Avoid consumption of unpasteurized milk and cheese.

Isolation and Decontamination: Standard precautions for healthcare workers. Person-to-person transmission via tissue transplantation and sexual contact have been reported but are insignificant. Environmental decontamination can be accomplished with a 0.5% hypochlorite solution.

Botulinum

Signs and Symptoms: Ptosis, generalized weakness, dizziness, dry mouth and throat, blurred vision and diplopia, dysarthria, dysphonia, and dysphagia followed by symmetrical descending flaccid paralysis and development of respiratory failure. Symptoms begin as early as 24 to 36 hours but may take several days after inhalation of toxin.

Diagnois: Clinical diagnosis. No routine laboratory findings. Bioterrorism should be suspected if multiple casualities simultaneously present with progressive descending bulbar, muscular, and respiratory weakness.

Treatment: Intubation and ventilatory assistance for respiratory failure. Tracheostomy may be required. Administration of heptavalent botulinum antitoxin may prevent or decrease progression to respiratory failure and hasten recovery.

Prophylaxis: Pentavalent toxoid vaccine (types A, B, C, D, and E) is available as an Investigational New Drug (IND) product for those at high risk of exposure.

Isolation and Decontamination: Standard precautions for healthcare workers. Toxin is not dermally active and secondary aerosols are not a hazard from patients. Hypochlorite (0.5% for 10 to 15 minutes) and/or soap and water.

Viral Hemorrhagic Fevers (VHF)

Signs and Symptoms: VHFs are febrile illnesses that can be complicated by easy bleeding, petechiae, hypotension, and shock. Constitutional symptoms such a malaise, myalgias, headache, vomiting, and diarrhea may occur in any of the hemorragic fevers.

Diagnosis: Definitive diagnosis rests on specific virologic techniques. Significant numbers of persons with a hemorrhagic syndrome should suggest the diagnosis of a viral hemorrhagic fever.

Treatment: Intensive supportive care may be required. Antiviral therapy with ribavirin may be useful in several of these infections. Convalescent plasma may be effective in Argentine hemorrhagic fever.

Prophylaxis: The only licensed VHF vaccine is yellow fever vaccine. Prophylactic ribavirin may be effective for Lassa fever, Rift Valley fever, CCHF, and possibly HFRS.

Isolation and Decontamination: Contact precautions for healthcare workers. Decontamination is accomplished with hypochlorite and phenolic disinfectants. Isolation measures and barrier nursing procedures are indicated.

Venezuelan Equine Encephalitis (VEE)

Signs and Symptoms: Sudden onset of illness with generalized malaise, spiking fevers, rigors, severe headache, photophobia, and myalgias. Nausea, vomiting, cough, sore throat, and diarrhea may follow. Full recovery takes 1 to 2 weeks.

Diagnosis: Clinical diagnosis. Physical findings are usually non-specific. The white blood cell count often shows a striking leukopenia and lymphopenia. Virus isolation may be made from serum, and in some cases throat swab specimens. Both neutralizing or IgG antibody in paired sera or VEE specific IgM present in a single serum sample indicate recent infection.

Treatment: Supportive only.

Prophylaxis: A live, attenuated vaccine is available as an investigational new drug. A second, formalin-inactivated, killed vaccine is available for boosting antibody titers in those initially receiving the live vaccine.

Isolation and Decontamination: Standard precautions for healthcare workers. Human cases are infectious for mosquitoes for at least 72 hours. The virus can be destroyed by heat (80 degrees centigrade for 30 minutes) and standard disinfectants.

Q Fever

Signs and Symptoms: Fever, cough, and pleuritic chest pain may occur as early as ten days after exposure. Patients are not generally critically ill, and the illness lasts from 2 days to 2 weeks.

Diagnosis: Q fever is not a clinically distinct illness and may resemble a viral illness or other types of atypical pneumonia. The diagnosis is confirmed serologically.

Treatment: Q fever is generally a self-limited illness even without treatment. Tetracycline or doxycycline are the treatments of choice and are given orally for 5 to 7 days. Q fever endocarditis (rare) is much more difficult to treat.

Prophylaxis: Treatment with tetracycline during the incubation period may delay, but not prevent, the onset of symptoms. An inactivated whole cell investigational vaccine is effective in eliciting protection against exposure, but severe local reactions to this vaccine may be seen in those who already possess immunity.

Isolation and Decontamination: Standard precautions are recommended for healthcare workers. Person-to-person transmission is rare. Patients exposed to Q fever by aerosol do not present a risk for secondary contamination or re-aerosolization of the organism. Decontamination is accomplished with soap and water or after a 30 minute contact time with 5% microchem plus (quaternary ammonium compound) or 70% ethyl alcohol.

Staphyloccal Enterotoxin B (SEB)

Signs and Symptoms: From 3 to 12 hours after aerosol exposure, sudden onset of fever, chills, headache, mayalgia, and nonproductive cough. Some patients may develop shortness of breath and retrosternal chest pain. Fever may last 2 to 5 days, and cough may persist for up to 4 weeks. Patients may also present with nausea, vomiting, and diarrhea if they swallow toxin. Presumably, higher exposure can lead to septic shock and death.

Diagnosis: Diagnosis is clinical. Patients present with a febrile respiratory syndrome without CXR abnormalities. Large numbers of persons presenting with typical symptoms and signs of SEB pulmonary exposure would suggest an intentional attack with this toxin.

Treatment: Treatment is limited to supportive care. Artificial ventilation might be needed for very severe cases, and attention to fluid management is important.

Prophylaxis: Use of protective mask. There is currently no human vaccine available to prevent SEB intoxication.

Isolation and Decontamination: Standard precautions for healthcare workers. Hypochlorite (0.5% for 10 to 15 minutes) and/or soap and water. Destroy any food that may have been contaminated.

Conclusion

Will a bioterrorism incident ever occur in Oklahoma? Hopefully not, but as Yogi Berra once said, "Predictions are hazardous, especially when they involve the future." Although it is not possible to know if bioterrorism will ever be employed here, we are certainly aware that events beyond imagination can occur. It is therefore in our best interest to understand this new threat so that we can plan for and respond appropriately should the unthinkable occur again. J

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Screening for Gestational Diabetes: An Evidence-Based Approach

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The primary goal of medicine should be to improve the health of patients. Evidence-based medicine is the utilization of evidence from studies published in the medical literature to help clinicians make decisions with and for their patients. Ideally the evidence should be patient-oriented, demonstrating improvements in actual patient outcomes, not just physiologic parameters or other intermediate endpoints. This concept is important in making decisions about screening tests, since this is how clinicians can determine if the screening test will actually improve patients' (and in the case of obstetrics, the neonates') outcomes. The purpose of this article is to examine screening for gestational diabetes from this perspective, discuss the current recommendations, and make suggestions for its utilization in clinical care.

Background

Gestational diabetes mellitus (GDM) is carbohydrate intolerance first detected during pregnancy. It was initially noted that its presence increased the risk of the subsequent development of overt diabetes in the mother;[1] observational data published in the 1970s[2] showed a correlation between GDM and perinatal mortality. A group of experts, the International Workshop-Conference on GDM, convened in 1979[3] by the American Diabetes Association (ADA) recommended screening all pregnant women for GDM based on the assumption that diagnosing and treating affected women would improve their neonates' outcomes by reducing the incidence of complications associated with diabetes, especially macrosomia. This recommendation was endorsed by the ADA and was re-issued following subsequent conferences in 1985 and 1991, and screening was widely adopted in the United States.

There are two types of diabetes mellitus—type 1 (also called IDDM), characterized by insulin deficiency, and type 2 (or NIDDM), characterized by insulin resistance. Most pre-existing diabetes in pregnancy described in the literature is type 1, which is associated with birth defects and significantly increased neonatal morbidity and mortality, especially if poorly controlled. Gestational diabetes is never type 1; a woman who happened to develop new type 1 diabetes during pregnancy might initially appear to have GDM, but her clinical course (insulin requirements, development of ketoacidosis) would eventually identify her as having type 1 diabetes. Women diagnosed with GDM may have mild glucose intolerance, more severe glucose intolerance, or undiagnosed pre-existing type 2 diabetes. This range of severity makes interpretation of outcomes data difficult; some studies include atypical populations (eg, Pima Indians) with more severe glucose intolerance, whose outcomes may be different than those in populations with milder degrees of glucose intolerance.

The prevalence of GDM reported in the literature varies widely and depends upon the population studied and the diagnostic criteria used; the overall prevalence in the United States appears to be 2% to 3%. Risk factors for GDM include obesity (especially weight gain in early adulthood), advancing age, a family history of type 2 diabetes, and cigarette smoking;[4] certain racial or ethnic groups (African-Americans, Hispanics, and especially Native Americans) also have a higher prevalence. Recent data indicate that the prevalence is under 1% in women without those risk factors.[5]

Screening and Diagnostic Tests

Based on the recommendations noted above, many clinicians screen women for GDM at 26

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Table 1. Criteria for Diagnosis of GDM

	Plasma Glucose Level (mg/dl)		
	O'Sullivan Criteria (100g)		World Health
Time	NDDG Canversian	Carpenter Canversian	Organization Criteria (75 g)
Fosting	105	95	95
1-hour	190	180	180
2-hour	165	155	155
3-hour	145	140	

Table 2. Classification of Diabetes in Pregnancy

Class	Onset Age (years)		Duration (years)	Vascular Disease	Insulin Need
A1	Any		Any	0	0
A2	Any		Any	0	+
B	>20		<10	0	+
C	10-19	or	10-19	0	+
D	<10	or	>20	+	+
F	Any		Any	+	+
R	Any		Any	+	+
T	Any		Any	+	+
H	Any		Any	+	+

to 28 weeks gestation. Some favor screening all women (universal screening) while others screen based on risk factors: women with risk factors or symptoms or signs of diabetes (eg, glycosuria) may also be screened at other times during pregnancy.

The screening test usually used in the United States is the 1-hour glucose screen, a blood glucose obtained one hour after a 50-gram oral glucose load. A value of 140 mg/dl is commonly used as the upper limit of normal, although lower values (eg, 130 mg/dl) are recommended by some authors and used by some clinicians. A lower value will increase the sensitivity of the test (ie, reduce false negatives) but will reduce the specificity, leading to more false positives. Much of the literature on GDM screening involves discussions of the optimum value to use, alternative screening methods, and universal versus risk-based screening.

Women with a positive screening test undergo a diagnostic test. The usual diagnostic test in the United States is a 3-hour glucose tolerance test (GTT) with a 100 gram oral glucose load, usually interpreted using normals based on the O'Sullivan criteria.[1] Women with two or more abnormal values on the 3-hour GTT have a positive test and, by definition, have GDM. These women are typically treated with a calorie-restricted diet and in some cases insulin; the specifics of treatment are beyond the scope of this article. Women with one abnormal value on the 3-hour GTT do not have GDM, but some authorities recommend repeating the test in those cases, since some will have a positive repeat test.

There are several sets of normal values for the 3-hour GTT (Table 1). The National Diabetes Data Group (NDDG) values are widely used; they are conversions to plasma glucose values from O'Sullivan's original values, which were based on whole blood. The conversion factor used has been questioned, and some clinicians use lower values based on other conversions such as those proposed by Carpenter and Coustan, which were endorsed by a recent international workshop.[6] Outside of the United States, values based on World Health Organization criteria from a 2-hour GTT are usually used. These varying methods and values probably account for much of the inconsistency in the literature and make comparisons of different studies, especially from different countries, very difficult.

There is no system for noting the severity of the glucose intolerance on the 3-hour GTT—a woman with two values each one point above normal has a positive test, as does a woman with four values all 100 points above normal. As noted in Table 2, there are two categories of GDM based on whether insulin is used or not, but there is wide variation in providers' thresholds for using insulin, so this distinction is arbitrary.

Benefits of Screening — The Theory

The early observational data showing a correlation between GDM and perinatal mortality was published during an era when perinatal mortality was much higher than it is now, and only women with specific indications were screened. Those studies did not control for confounding variables, such as maternal age or obesity, that would increase the risk of both GDM and perinatal mortality, so the correlation may have been due to the underlying risk factors that prompted screening. More recent literature has focused on screening for and treating GDM to reduce other perinatal complications.

Infants born to mothers with GDM have a higher risk of macrosomia, hypoglycemia, hypocalcemia, and hyperbilirubinemia. The last three of these are usually transient and of questionable clinical importance, since they rarely lead to any long-term consequences for the neonate. Most of the research on GDM has focused on how its diagnosis and treatment might reduce the risk of macrosomia and its complications.

There is no consensus on the definition of macrosomia. It is usually defined as a birth

weight of 4,000 or 4,500 grams; the American College of Obstetrians and Gynecologists (ACOG) considers 4,500 grams a reasonable definition[7] and this figure is commonly used in the literature. The overall prevalence of macrosomia (> 4,500 g) is about 0.5% to 1%; risk factors include maternal obesity (and higher maternal birth weight), postterm pregnancy, multiparity, macrosomia in a prior infant, male sex, and maternal diabetes. Since obesity is also a risk factor for GDM, much of the association between GDM and macrosomia may exist because obesity predisposes to both.

Macrosomia itself is not harmful, but it increases the risk of other adverse maternal and neonatal outcomes, including shoulder dystocia, brachial plexus injury (Erb's palsy), operative delivery, and maternal lacerations. Reducing the incidence of macrosomia should, in theory, reduce the incidence of these complications.

Benefits of Screening — The Reality

Ideally, evidence-based medicine relies on the most solid evidence—the clinical outcomes of one or more randomized controlled trials. Unfortunately, there have been no such trials published examining the potential benefit of screening for GDM, so we must rely on more indirect evidence. This includes observational data, the characteristics of the screening test, and evidence regarding the outcomes of treatment.

One observational study[8] compared women followed by two groups of obstetricians—one that screened most patients for GDM and one that did not. The screened group had more interventions and a higher cesarean section rate, but the rates of macrosomia and neonatal outcomes were the same. However, since the two groups of women may not have had similar risk profiles, and the two groups of obstetricians may have had different practice styles, the results may not be reliable.

Stephenson has published a review on GDM screening,[9] and demonstrated that the screening test has poor sensitivity, specificity, and reproducibility. A recent study[5] of an academic family practice center population showed that 12.8% of the women had a positive 1-hour glucose screen, but only 22% of those had a positive 3-hour GTT. There are also problems with the diagnostic test: it is based data from an atypical population in the 1950s, there is no consensus on its normal values, and it is poorly reproducible, with the variation within one individual being higher than the variation between individuals. Moses[10] studied women with GDM in a previous pregnancy and found the recurrence rate in a subsequent pregnancy was only 30%. In addition, the test is simply positive or negative, which does not account for the degree of glucose intolerance, which correlates with the risk of macrosomia and other adverse outcomes.[11]

Does diagnosing and treating GDM reduce the incidence of macrosomia? Although the presence of GDM increases the risk of macrosomia, other risk factors are more important. Spellacy et al[12] showed that while GDM increased the risk of macrosomia three-fold, obesity increased it 25-fold and postmaturity increased it six-fold; in that study only 5.1% of the infants with macrosomia were born to women with GDM. In Stephenson's review,[9] each study on treatment of GDM showed a reduction in the incidence of macrosomia, but combined data indicated an average reduction in birthweight of only 87 g. A more recent study[13] showed that tight control of GDM reduced average birthweight by 107 g compared to routine care, but there were no differences in actual patient outcomes. One observational[8] and two retrospective studies[14,15] failed to show any significant reduction in macrosomia between screened and unscreened groups.

Does reducing the incidence of macrosomia reduce the risk of shoulder dystocia and associated complications? Although shoulder dystocia is more common in macrosomic infants, the large majority of cases (93% in one study[16]) occur in infants without macrosomia. Lipscomb et al[17] examined the outcomes of 227 macrosomic (>4,500g) infants and found that although 18.5% of those delivered vaginally had shoulder dystocia, only 3% of those (0.6% of the total) had brachial plexus injuries and all recovered fully by 2 months of age; there was no birth asphyxia or perinatal mortality. The fact that shoulder dystocia is uncommon and usually occurs in the absence of macrosomia, as well as the questionable impact of GDM treatment on the incidence of macrosomia, are likely why even those studies showing reductions in birth weight have failed to show significant improvements in actual neonatal outcomes.

Does reducing the incidence of macrosomia reduce cesarean section rates? A meta-analysis of trials of insulin treatment[18] showed a reduction in the incidence of macrosomia, but no reduction in the cesarean section rate. As Naylor et al[19] demonstrated, the relationship between macrosomia and cesarean section can be more complex than expected. They showed that treatment of GDM normalized birth weights, but

that the cesarean section rate was about 33% with or without macrosomia, and concluded that the physicians' knowledge that the patients had GDM may have lowered their threshold for surgical intervention. In a study comparing the management of GDM by obstetricians and family physicians, Jackson et al[20] showed that the family physicians prescribed insulin less frequently but had the same rate of macrosomia and a lower cesarean section rate. Since macrosomia cannot be reliably predicted,[7] having risk factors for macrosomia, including GDM, may increase a woman's odds of having a cesarean section even if her infant is not macrosomic.

Risks of Screening

The costs must be considered in any screening program. Although the economic cost of initial GDM screening is fairly low (about $20), the costs of additional testing must also be included. About 13% of women will have a positive screening test (about 25% if 130 mg/dl is used as the upper limit of normal) and will undergo 3-hour GTT, and women with confirmed GDM will be given nutritional counseling and follow-up glucose testing. Many of those women will eventually receive insulin therapy, home glucose monitoring, and more intense follow-up, which may include non-stress tests, ultrasound examinations, and labor induction. Once a woman has been diagnosed with GDM, she is also at higher risk for cesarean section, with its potential complications, including its impact on future delivery options.

Non-economic costs must also be examined. Patients with positive screening tests may suffer anxiety or other health concerns. Kerbel et al[21] demonstrated this with GDM—women with a positive screening test who turned out not to have GDM still had lower perceptions of their health. These concerns also extend to their children—Feig et al[22] showed that women diagnosed with GDM were more worried about their health and rated their children as less healthy 3 to 5 years later. The additional testing and follow-up "medicalizes" a natural process, increases the woman's time spent in the medical system, and may interfere with work, family relations, and other important issues during pregnancy. Each additional test, especially the non-stress test, may be falsely positive and lead to further testing and/or intervention.

Treatment may also cause adverse consequences. Langer et al[23] showed that women with tightly controlled GDM had twice the risk (20% vs 10%) of having a small for gestational age infant. The clinical impact of this is unclear, but complications in those infants might offset some of the potential benefits of treatment. Insulin therapy, especially with tight control, also increases the risk of maternal hypoglycemia and its complications.

Recommendations: Past and Present

Universal screening has been recommended in the past by the ADA (see Background), and in 1986 the ACOG stated "...(S)ome recommend that all pregnant women should be screened.... Patients should be screened at approximately 24-28 weeks of gestation...."[24] However, more recent guidelines, which are more evidence-based, no longer make that recommendation.

In 1994 the ACOG guidelines on GDM stated, "There are no data to support the benefit of screening, however, and further studies are needed on which to base a recommendation,"[25] and their most recent antepartum record form has GDM screening listed "when indicated." The United States Preventive Service Task Force, a group that developed evidence-based screening guidelines, reported that there is insufficient evidence to support screening for GDM.[26] An expert committee on diabetes convened in 1995 under the auspices of the ADA[27] recommended that low-risk women (those who are under 25 years of age with normal body weight; who have no first-degree relatives with diabetes; and who are not Hispanic, Native American, Asian, or African-American) do not need to be screened for GDM, and the most recent (Fourth) International Workshop-Conference on GDM made similar recommendations.[6]

In other countries, screening for GDM is also questioned. The Canadian counterpart to the US Preventive Services Task Force also finds no evidence to support screening,[28] and an article in the British literature is entitled "Gestational diabetes—A non-entity?"[29] Organizations issuing prenatal care guidelines in Australia and Germany do not include GDM screening in their recommendations.[30]

An Evidence-Based Approach to Screening

Screening for GDM has followed a common path in medicine—it has been adopted on theoretical grounds before its efficacy has been properly tested.[31] In spite of new evidence and new recommendations, it has now become part of "routine" prenatal care for many providers, perpetuating its use and causing reluctance to study it further.

There is no direct evidence demonstrating a benefit from screening for GDM; the indirect evidence suggests screening is not beneficial, and there are clear disadvantages to screening. Further, the evidence that the treatment of GDM benefits patients is sparse, inconsistent, and often focused on intermediate endpoints (eg, birth weights) rather than patient-oriented outcomes. No cost-benefit analysis of screening has been published.

The primary purpose of screening for GDM is preventing macrosomia and its complications, including shoulder dystocia and cesarean section. However, macrosomia is rare and occurs mostly in infants whose mothers do not have GDM. Shoulder dystocia is also rare, and occurs mostly in infants who are not macrosomic. Even if diagnosing and treating GDM completely prevented macrosomia, it would have very little impact on the overall prevalences of macrosomia or shoulder dystocia. Treating GDM has not been shown consistently to reduce cesarean section rates; diagnosing it may actually increase the rate.

When recommendations from respected authorities change, it is incumbent upon providers to be aware of these changes and to incorporate them into their practices. When there is conflict between a common screening practice and evidence-based guidelines, it is especially crucial to discuss openly with the patient the risks and benefits of screening and solicit her input into the decision. These issues have been discussed from an ethical standpoint,[32] including the role of informed consent.[33]

Conclusions

There is currently no evidence that universal screening for GDM benefits pregnant women or their offspring, and it generates costs and harmful effects. Only a properly designed, randomized, controlled trial could provide better information, and perhaps it is time for investigators and clinicians with an interest in GDM to design and run such a study, which could then guide clinicians in the future. If benefits of screening are demonstrated, cost-effectiveness will also need to be considered.

For now, those who provide care to pregnant women should look closely at the current recommendations regarding GDM screening. The most recent recommendations of several expert panels no longer include universal screening, and this practice should be discontinued. Those who prefer to screen should limit screening to women with risk factors, counsel those women about the clear risks and uncertain benefits of screening, and solicit the woman's input into the decision. Those who deliver babies must understand that the clinical complications traditionally associated with GDM, especially shoulder dystocia, will continue to occur, usually during those deliveries in which they are least expected. ▯

Author's Note

Since this article was submitted, Kjos and Buchanan published a review article on gestational diabetes (NEJM. 1999;341:1749.), which summarizes current screening recommendations and includes a protocol for screening based on risk status. A critique of that article by JL Ecker et al and Kjos and Buchanan's reply (NEJM. 2000;342:896-897.) further highlight the controversies regarding GDM.

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Smoking Cessation Overview

Shawn K. Lee, MD; David C. Levin, MD; Robert McCaffree, MD

This article summarizes the primary recommendations of the Agency for Health Care Quality's recently published Smoking Cessation Clinical Practice Guidelines. Specific recommendations are outlined to assist physicians in treating patients who smoke to end their use of tobacco.

Introduction

According to the Oklahoma State Department of Health's annual report on "The State of the State's Health," Oklahomans have a greater loss of Disability-Adjusted Life Years than the average US citizen. This is due largely to high rates of lung disease, heart disease, stroke, and injuries, all of which are in part to lifestyle choices, including the use of tobacco and alcohol, obesity, and failure to use seatbelts. In fact, tobacco use is the greatest cause of preventable morbidity and mortality in Oklahoma, as well as the United States. However, as a subject of preventive medicine, tobacco use prevention or cessation is relatively ignored. Cholesterol lowering, use of aspirin and beta-blocking agents, screening colonoscopy, treatment of mild to moderate hypertension, and other preventive interventions receive far more emphasis, despite clear evidence of morbidity and mortality benefits from smoking cessation.[1] This disinclination on the part of physicians to effectively and consistently address smoking cessation with their patients may be the result of lack of effective counseling skills, perception of lack of patient interest in cessation, and frustration with low success rates. Fortunately, there is a large body of evidence demonstrating valid and effective techniques for successful smoking cessation. Moreover, surveys both in Oklahoma and nationally reflect that 70% to 75% of current adult smokers want to quit, and 50% of underage smokers in Oklahoma want to quit. Unfortunately, only half of all smokers recall receiving any advice from their physician to stop smoking. The purpose of this article is to review information on smoking cessation, with emphasis on the recently published clinical practice guidelines of the US Agency for Health Care Quality (AHCQ; formerly the Agency for Health Care Policy and Research).[2] It should also be stated that while this article refers to smoking tobacco, tobacco use in all forms, including spit tobacco, should be discouraged.

A Few Statistics

The current prevalence of smoking among adults in Oklahoma is 24.6%, slightly above the national average. Nationwide, cigarette smoking is responsible for 430,000 deaths annually, or one out of every five deaths. In Oklahoma, more than 6,100 people die each year of smoking-caused diseases. Oklahoma has the ninth-highest percentage of smoking-caused deaths in the United States.[3] Thirty percent of cancer deaths are attributable to smoking.[4] It has been estimated that 35% of low birth weight babies can be attributed to maternal smoking. The impact of smoking on morbidity in many diseases, such as asthma and respiratory disease in children, is similarly devastating.

However, the potential benefits of smoking cessation are very encouraging. The relative risk for developing lung cancer in males falls from 22.4 in smokers to 9.4 among former smokers (11.9 and 4.7, respectively, in females).[5] Similarly, the risk for recurrent myocardial infarction, cardiac arrest, and stroke fall to approximately that of non-smokers within one to three years following smoking cessation.[5-8] The risk of low birth weight clearly will fall immediately if the mother does not smoke dur-

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ing pregnancy. Since physicians will see 70% of smokers in their practice each year,[9] there is the potential to have an enormous impact on the health of our smoking patients.

Overview of AHCQ Recommendations to Clinicians

Review of available literature found three treatment elements to be particularly effective, either alone or in combination:

1. Social support (in the form of encouragement and support from the clinician);
2. Skills training/problem solving (in the form of practical advice and techniques from the clinician); and
3. Nicotine replacement therapy (at the time the guidelines were published, data from the use of bupropion were scant and were not included).

Specific recommendations for clinicians are outlined in the sections below.

Identify all tobacco users

The first major objective as outlined in the AHCQ clinical practice guideline is to assess the smoking status of every patient, and provide a smoking cessation intervention when appropriate. This should occur at each clinic appointment. To enable the identification of smokers, the guideline recommends that current smoking status be made a part of the vital signs section of the medical record. This should be recorded by the clinical staff along with the vital signs on each visit.

Advise

Regardless of their willingness to quit, every patient using tobacco should be urged to quit. The guideline emphasizes that the advice should be clear: "I think it is important for you to quit smoking now," and strong: "As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your current and future health." It should also be personalized to the concerns (economic, health, family) of the patient that will best serve to motivate that individual to attempt smoking cessation. It is additionally recommended that the clinic staff reinforce the cessation message and support the patient's attempt to quit.

Identify those willing to make a quit attempt

After advising the patient of the importance of smoking cessation, each smoker should be asked if they are willing to make an attempt to quit smoking. The patient should be informed that effective treatments are available. The patient can be encouraged by mentioning that half of all people who have ever smoked have now quit. It is also important to communicate confidence in the patient's ability to quit. If the patient clearly states that they are not ready to make an attempt, the clinician should provide a motivational intervention.

Deliver motivational interventions

This concept refers to providing information to the patient that is likely to have a favorable impact on their decision to make a cessation attempt. To be an effective motivational intervention, it should follow the rule of the 4Rs, which are as follows:

Relevance

The information about the detriments of smoking should be relevant to the concerns of the patient, similar to the personalized advice as mentioned above, but more detailed. This will obviously vary from one patient to another but might include impact on family, pregnancy, effects on personal hygiene, physical fitness, and other personal concerns.

Risks

These should be brought up in detail with the patient, again emphasizing the issues most relevant to the patient. They can be divided into acute (shortness of breath, gastro-esophageal reflex disorder, arrythmias, impotence), long-term (emphysema, myocardial infarction, strokes, cancer, peripheral vascular disease), and environmental (increased risk of cancer in spouse and children; increased incidence of sudden infant death syndrome, asthma, and smoking in children).

Rewards

Similarly, these should be thoroughly discussed with the patient in accordance with their relevance and include quality of life, self-esteem, increased energy, saving money, better hygiene, improved life-expectancy, and better health for their children.

Repetition

These motivational interventions should be re-addressed with each visit.

Provide assistance

Once the patient is ready to make a quit attempt, the clinician needs to be ready to assist the

patient by providing a cessation plan. Begin by setting a quit date. The personal preferences of the patient should be honored, but ideally the quit date should be within two weeks of the clinic visit. During that interval, advise the patient to inform his or her family and close contacts of the impending quit attempt, and request their support and assistance. The patient should also prepare their environment by removing cigarettes, ashtrays, and any other smoking material. If the patient has made any serious previous cessation attempts, these should be reviewed with the patient to determine what techniques were successful and what led to the relapse.

Potential pitfalls should be anticipated, especially for the critical few weeks following the quit date. It is important for the patient to identify and prepare for scenarios that are likely to create strong urges for the patient to smoke. Examples of such scenarios include stressful conditions at work (such as deadlines) or home (such as arguments with a spouse). The time right after eating is particularly difficult for recent smokers. The patient should avoid places that are likely to provoke the desire to smoke, such as a club. The presence of other smokers in the household is another problem; ideally, any other smokers in the household should make a concurrent attempt to quit smoking. Otherwise, a plan to minimize the exposure to smoking within the household will need to be implemented.

Certain behavior and cognitive activities have been shown to be helpful in distracting the patient from smoking urges. The patient can be informed that most smoking urges last only about three minutes and that certain activities, such as deep breathing, or cognitive exercises, such as reviewing the benefits of being a nonsmoker, can help to overcome these urges.

Other information that should be provided to the patient concerns the addictive nature of smoking. Although the patient may recognize this as obvious, he or she should be made to understand the nature of nicotine withdrawal—both the symptoms and the duration. This awareness will allow the patient to be better prepared for this difficult state. It should also be emphasized to the patient to maintain strict abstinence; not even a single puff should be tolerated after the quit date. Research findings have indicated that 95% of ex-smokers who take only one puff will relapse. Additionally, alcohol use has been shown to increase the rate of relapse, and its use should be avoided during the first few weeks after the quit attempt.

Table 1. Instructions and Recommendations for Use of Nicotine Patches

Dosage: Recommended duration of treatment is eight weeks. No significant increase in efficacy has been demonstrated for longer treatment periods. Based on this finding, appropriate dosing schedules are as follows:

Brand	Duration, wk	Dose, mg/h
Nicoderm and Habitrol	4	21/24
	Then 2	14/24
	Then 2	7/24
Prostep	4	22/24
	Then 4	22/24
Nicotrol	4	15/16
	Then 2	10/16
	Then 2	5/16

Prescribing instructions:

No smoking while on the patch.

At the start of each day, the patient should place a new patch on a relatively hairless location between the neck and the waist.

There are no activity restrictions while on the patch.

Patches should be applied as soon as patients waken on their quit day.

Nicotine replacement therapy

Nicotine replacement therapy (NRT), specifically the nicotine patch and nicotine gum, has been proven to have a significant positive impact on smoking cessation. The AHCQ guidelines recommend using the nicotine patch for routine clinical practice. Although research indicates similar efficacy for both the patch and gum, the patch is preferred based on findings of fewer compliance problems and ease of use. Factors supporting the use of nicotine gum include patient preference and previous difficulty with the nicotine patch. Transdermal nicotine doubles the abstinence rates at 6 and 12 months, independent of counseling efforts, when compared to placebo.[10] Except in special circumstances, NRT should be offered to every patient and its use encouraged. Caveats to this would include pregnancy and patients with certain cardiac conditions such as recent myocardial infarction (4 weeks), serious or worsening angina, or serious arrythmias. In these groups of patients, the risks and benefits of NRT should be discussed and the patient should initially be encouraged to make the cessation attempt without NRT.

Specific instructions and recommendations for use of the patches are shown in Table 1.

For those who have difficulty with the patch or prefer the gum (nicotine polycrilex resin), it is available in 2 mg and 4 mg strengths, with the higher strength recommended for those who smoke more than 24 cigarettes per day. Physicians should instruct the patient to begin

using one piece of gum every 1-2 hours initially, gradually decreasing use over 6 weeks. The gum should be chewed initially until a tingling sensation is felt in the gums, then parked in the buccal mucosa until the tingling subsides. The patient should be instructed to alternate between slow chewing and parking the gum for about 30 minutes. Acidic beverages such as coffee and juice should be avoided during this time because they inhibit the absorption of nicotine.

Newer forms of NRT have been approved since the AHCQ recommendations were published, including the nicotine nasal inhaler and the nicotine oral vapor inhaler. The water-based, metered-dose nasal spray delivers 0.5 mg of nicotine per spray. The usual dose is 1-2 sprays per hour, up to 5 sprays per hour or 40 sprays per day. It can be accompanied by local irritation, sneezing, watery eyes, and cough, as well as a higher risk for nicotine dependence because of its rapid onset and patient control of nicotine delivery. The oral vapor inhaler contains 10 mg of nicotine which can deliver up to 4 mg to the patient. A porous cartridge is inserted into a holder resembling a cigarette and inhaled. The usual initial use is 6 to 16 cartridges per day for up to 12 weeks, followed by a gradual reduction, if needed, over the next 6 to 12 weeks.

One randomized, double-blind, placebo-controlled study[11] compared the nicotine patch alone to the patch and nicotine nasal spray. Abstinence rates at one year for the nicotine nasal spray were 27% versus 11% in the patch and placebo group. In a 1997 randomized, double-blind, placebo-controlled study,[12] the nicotine vapor inhaler was compared to placebo inhaler. The inhalers could be used up to six months. At one year follow-up, the rate of continuous abstinence was 28% in the nicotine inhaler group and 18% in the control group.

Non-nicotine pharmacologic therapy

More recently, newer drug therapies for smoking cessation have been found to be effective. Currently only bupropion has been approved by the FDA. Bupropion was initially marketed as an antidepressant, but is chemically unrelated to any other antidepressants. It is more effective in those with higher motivations to quit. It is contraindicated in those with seizure disorders, those predisposed to seizure disorders because of bulimia or anorexia nervosa, or those on monamine oxidase inhibitors (MAOI). At least 14 days should elapse between cessation of the MAOI and beginning bupropion. It should be used with caution in persons taking a noradrenergic antidepressant agent, in those with medical conditions which might predispose them to seizures, and in those with hepatic dysfunction or end-stage cirrhosis.

Bupropion should be used for 7 to 12 weeks, beginning with 150 mg for the first three days, then 150 mg twice daily. It should be started one week before the quit date. The patient should be instructed to swallow the tablets whole, not crush or chew them.

In one randomized, double-blind, placebo-controlled trial,[13] bupropion alone was compared with a nicotine patch alone, bupropion plus a nicotine patch, or placebo. Patients received standard courses of the nicotine patch and 9 weeks of bupropion. At one year, the bupropion groups demonstrated significantly higher continuous abstinence rates compared with placebo and nicotine patch-alone groups. No difference existed between the two bupropion groups.

Arrange follow-up

A strong association has been noted between the amount of clinical contact with smoking patients and the effectiveness of the smoking cessation treatment. Ideally, treatment for smoking cessation should span four to seven sessions, each lasting 20 to 30 minutes, and spread out over a period of eight weeks or longer. The initial follow-up contact can be accomplished by telephone or in person. Ideally it should occur within the first week. A second contact should be made within a month after the quit date. If the patient has maintained abstinence, he or she should be congratulated. If smoking occurred, the clinician and patient should review the circumstances responsible. Other impediments to cessation that the patient has encountered should also be addressed, and strategies implemented to minimize similar occurrences in the future. Any problems or concerns with nicotine replacement therapy should also be discussed. The patient should be recommitted to total abstinence. If appropriate, the clinician should consider referral to a more specialized program.

Relapse prevention

As a result of the high relapse rate after initial abstinence, it is important to implement preventive measures when indicated. The first three months after a smoker quits are critical, and patients in this window should have interventions scheduled either by telephone or with clinic visits. There are two categories of relapse prevention:

Minimal practice

These interventions should be a part of every encounter with a patient who has recently quit smoking. Components include providing congratulation and encouragement, as well as concern that the patient remains abstinent. The clinician should invite discussion by the patient, specifically asking them to review the benefits of smoking cessation, and the patient's successes in quitting, including the duration they have been abstinent and the period of withdrawal they have withstood. This is also the time to discuss problems encountered in maintaining abstinence, and anticipate future threats to continued abstinence.

Prescriptive interventions

These interventions are more personalized and specifically tailored to the problems that the patient has encountered or those about which the patient is concerned. Specific problems might include weight gain, depression, and other mood problems. Either treatment by the clinician or appropriate referral to a program or specialist may be indicated. If the patient reports prolonged symptoms of nicotine withdrawal, extending the nicotine replacement therapy may be considered by the clinician. If the patient is encountering a lack of support in his or her cessation attempt, the clinician might schedule additional follow-up contacts, or provide a referral to an appropriate counseling organization.

Weight gain

Many smokers, particularly women, are concerned about the potential of weight gain after quitting smoking. This concern can discourage many from wanting to make a quit attempt. The clinician should not attempt to deny the likelihood of weight gain or minimize its importance to the patient. Instead, the clinician should prepare the patient by explaining that the majority of patients do gain some weight after smoking cessation, but that it is generally limited to about ten pounds. Patients should be informed that weight gain is a natural part of smoking cessation, but that the health risks of the small amount of weight gain is negligible compared to the risks of continued smoking. The most effective strategy is to convince the patient to accept some amount of weight gain initially, and to avoid intensive weight loss strategies until the patient is no longer experiencing withdrawal symptoms and is confident that he or she will not return to smoking. Once smoking cessation has been accomplished and the potential for relapse is minimal, the issue of weight loss can be fully addressed.

Summary

In conclusion, the recently published Agency for Health Care Quality Smoking Cessation Clinical Practice Guidelines provides a consensus and evidence-based approach for the primary-care clinician to deliver an effective program of smoking cessation to their patients. The primary recommendations are as follows:

(1) The smoking status of every patient should be determined on every visit;
(2) Every smoker should be urged to quit and offered a smoking cessation intervention;
(3) Those patients not ready or willing to attempt smoking cessation should receive a motivational intervention to promote subsequent quit attempts;
(4) For patients ready to make a cessation attempt, the clinician should assist them by helping them set a quit date, help them prepare for quitting, and anticipate challenges to their quit attempt. If the patient or clinician feels that a more intensive program is indicated, the patient should be referred to a smoking cessation specialist;
(5) Nicotine replacement therapy is an effective aid to smoking cessation and, with a few exceptions, should be offered to every patient planning to quit smoking;
(6) All patients attempting to quit should have follow-up contact scheduled, preferably within the first week; and
(7) A dose-response relationship exists between the intensity and duration of a treatment and its effectiveness. In general, the more intense the intervention, the more effective it is in producing long-term abstinence from tobacco. However, cessation treatments as brief as 3 minutes are effective.

Although the AHCQ recommended only the nicotine patch or gum for use in smoking cessation, more recently bupropion has been shown to be effective in controlled clinical trials. These may have a place in addition to or in place of nicotine replacement therapy. Further clinical experience will better establish the role of this and other agents.

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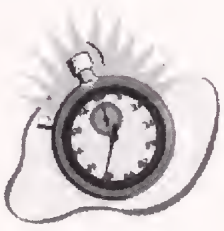
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Coaches—You Can Influence Youth



Know the Facts About Youth and Tobacco Use

- Smoking slows lung growth, decreases lung function, and reduces the oxygen available for muscles used in sports.
- Smokers suffer from shortness of breath almost three times more often than nonsmokers.
- Nicotine is addictive in ways like heroin and cocaine.
- Young people who do not start using tobacco by age 18 will most likely never start.
- Young people who use tobacco may be more likely to use alcohol and other drugs such as cocaine and marijuana.
- Spit tobacco and cigars are NOT safe alternatives to cigarettes; low-tar and additive-free tobacco products are not safe either.
- Tobacco use is the single most preventable cause of death in the United States, causing heart and lung diseases, cancers, and strokes.



Take a Stand—Early and Often

- Recognize your influence with young people. Don't use tobacco around players. Remind them of the importance of being tobacco-free.
- When talking to players, remember they relate more to messages about the immediate effects of tobacco use (such as poorer athletic performance) than to its long-term health threats.
- Adopt and enforce a tobacco-free policy for players, coaches, and referees.
- Send a copy of the tobacco-free policy home for parents to review.
- Make all practices, games, and competitions tobacco-free—on the field and sidelines and in the stands.
- Announce and display tobacco-free messages at games.
- Consider partnering with your local tobacco prevention programs. Voice your support for tobacco-free schools, sports, and other community events.

Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention
1-800-CDC-1311, (770) 488-5705, http://www.cdc.gov/tobacco

Patient Handout #5

DOCTOR'S DIARY

Violence in Perspective

Joe D. Haines Jr., MD

I've often wondered why the state requires a license to drive a car, but not to parent a child.

Of all the jobs I've held, none have been more daunting than parenthood. No other role has more far-ranging consequences and requires no formal training. For most parents, however, on-the-job training remains state of the art.

It may seem that our preparation for parenthood is negligible at best. Even those parents who devour volumes of child-rearing manuals feel woefully inadequate when unforeseen situations inevitably arise. Children have the disconcerting habit of not conforming to experts' predictions.

Just when you feel confident that you have prepared for every eventuality, the little beggars raise the ante. Take the issue of violent toys, for example. Most reasonable parents would agree that children today are exposed to an excessive amount of violence on TV, in video games, and in movies. But oftentimes, in our zeal to create a perfect environment, adults tend to go overboard.

I recall my well-intentioned wife deciding not to give toy guns to our boys. The theory of this move is this: by not giving children violent toys, unhealthy aggressive behavior would be discouraged.

Whoever proposed this theory probably never raised boys.

With a knowing smile, I calmly agreed with my wife. No toy guns.

Not long after the ban, I heard the boys chasing each other in the yard, yelling out, "Kill, kill." They each had a wooden stick that had been fashioned into a makeshift rifle. What my wife failed to realize was that the rifle is part of the very soul of little boys. From the days cavemen hunted woolly mammoths in the Stone Age, males have been genetically programmed to use violence to survive. We are the descendants of those ancestors who were the best hunters and fighters.

Once my wife succumbed to the inevitable, a wide variety of toy firearms began to appear in the family arsenal. I'll never forget a family trip to Jackson Hole, Wyoming, when the boys were ages three and four. Like most kids, they felt right at home with the cowboy culture. By the time the vacation was over and we were boarding our flight home, the boys were outfitted in jeans, boots, hats, and a gun belt with a cap pistol.

As we proceeded through the final screening area, we were informed that FAA regulations required the cap pistols to be checked as baggage. Even in the heart of the Old West, the anti-toy gun sentiments prevailed. Fortunately, the boys took the bad news without a fuss. Perhaps they were secure in the knowledge that their .45 caliber Colt automatic toy pistols were safely concealed in their backpacks, ready for action.

I recently attended a writer's conference where one of the authors pleaded with us all to avoid violence in our stories. When I pointed out that violence per se was not necessarily "bad," I was viewed as a Neanderthal. It has become politically correct—in children's literature—to avoid violence of any kind. What I unsuccessfully tried to point out was that violence could be ennobling.

I was thinking about a story I'd just finished about the Civil War battle of New Market, in which the teenage cadets of the Virginia Military Institute fought so bravely. To omit the necessary violence in the story, especially involving the ten cadets who were killed, is to dishonor their memory. Another story that came to mind was that of David O. Dodd, a 17-year-old who was hanged by the Union Army as a spy. Rather than reveal the source of his information to save his life, Dodd went to the gallows.

Combat and hangings are indeed violent, but violence is not the point of these stories. The greater themes of loyalty, honor, duty, and bravery are the lessons to be learned. To omit violence from the Civil War is to be untruthful. What should be avoided in all literature is gratuitous violence. Violence for its own sake, for shock value, or as an unnecessary element in a story should not be condoned. Children should be protected from this gratuitous violence, for a society that does not place the welfare of its children foremost is fundamentally flawed.

Parents should teach their children that in today's society, circumstances sometimes require violence. Avoidance of violence is commendable when possible, but the judicious use of violence is sometimes the only proper course.

The fittest don't always survive by being passive. J

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Oklahoma Physician Promoted to Brigadier General

James Thomas Turlington, MD, was recently promoted to the rank of Brigadier General in the United States Air Force Reserves. Dr. Turlington's nomination order was signed by President Clinton on January 20, and approved by the United States Senate on March 1. He is the mobilization assistant to the command surgeon, Headquarters Air Mobility Command (AMC) at Scott Air Force Base in Illinois.

Dr. Turlington is in private practice as an urologist in Muskogee, Okla. He is currently on reserve status within the Air Force because regulations preclude active duty officers from operating a private medical practice; during wartime, Dr. Turlington assumes an active duty function of Assistant to Surgeon for Reserve Affairs.



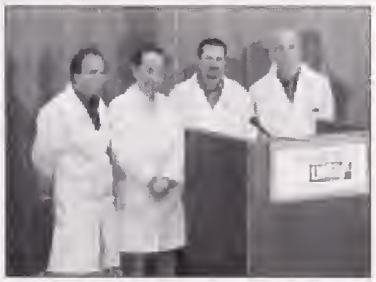
Brigadier General James Thomas Turlington, MD, (center) receives his general's stars from his commanding officer, General Tony Robertson, and his wife Cindy, at Scott Air Force Base near St. Louis.

Dr. Turlington joined the Air Force Reserves while completing his medical education at Baylor College of Medicine in Houston, receiving an early commission in reserve status. During his senior year of medical school, Dr. Turlington went on active duty, serving from 1970 to 1981. During Operation Desert Shield/Storm, Dr. Turlington was recalled to active duty as commander of the 11th Contingency Hospital (AFRES) at Lackland Air Force Base in Texas. Dr. Turlington's awards and decorations include: the Legion of Merit; the Meritorious Service Medal; the Air Force Commendation Medal; the National Defense Service Medal; the Air Force Outstanding Unit Award; the Air Force Longevity Service Award Ribbon with four oak leaf clusters; and the Air Force Training Ribbon. He is also rated a Chief Flight Surgeon.

Oklahoma Physicians Recognized for Contributions to Mental Health

Edward N. Brandt, Jr., MD, Phebe Tucker, MD, Murali Krishna, MD, Donald Cooper, MD, and Joseph Ripperger, MD, were recently honored by the National Alliance for the Mentally Ill (NAMI) Oklahoma for their contributions to the field of mental health in the Sooner State. Drs. Brandt, Tucker, and Krishna were honored for their roles as members of the State Chamber of Commerce Parity Coalition, where they advocated the need for insurance coverage for persons with mental illness equal to that of persons with any other disease or illness. Dr. Cooper received the Lifetime Achievement Award for his contributions to the practice of medicine and his openness in his personal battle with depression. Dr. Ripperger was honored for his work as a mental health provider and his outreach to other providers, family members, and the community.

Oklahoma Scientists Conducting Groundbreaking Research on Alzheimer's Disease



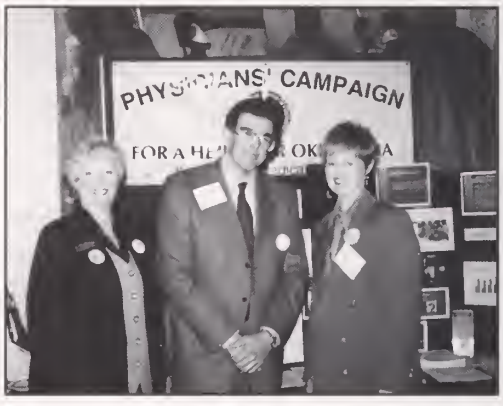
Dr. Jordan Tang (second from left), head of the Protein Studies Research Program at OMRF, leads the team that identified and named Memapsin 2 and developed an inhibitor for the enzyme. Pictured with Dr. Tang are members of the research team (L-R): Dr. Xinli Lin, Dr. Gerald Koelsch, and Dr. Jacques Ermolieff.

Researchers at the Oklahoma Medical Research Foundation (OMRF) are receiving local and national attention for their recent discoveries in the search for a treatment for Alzheimer's disease. Led by Jordan Tang, PhD, scientists at OMRF have positively identified the enzyme that is directly related to Alzheimer's disease, which they named Memapsin 2. In April, the team announced it had successfully designed a highly potent inhibitor for the enzyme. Of their work Dr. Tang says, "No other lab has achieved this level of design and potency of a Memapsin 2 inhibitor. We are hopeful that the design of the Memapsin 2 inhibitor will eventually lead to a drug which will effectively treat Alzheimer's disease."

OSMA Medicine Day at the Capitol



(L) Dr. Edward N. Brandt, Jr., Chair of the OSMA's Council on State Legislation and Regulation, and Sherry Strebel, OSMA Alliance member and Chair of Medicine Day 2000, welcomed physicians and their spouses to the Capitol on March 22. Medicine Day is an annual event where OSMA members, medical students, and spouses visit the Capitol to discuss legislative issues of importance to Oklahoma's physicians and their patients.



(R) Informational displays and booths were part of the OSMA's Medicine Day 2000. Among those providing information were (from left) Joy Leuthard, OSMA Director of Health Care Policy and Research, Dr. Robert J. Weedn, OSMA President-elect and Chair of the Physicians' Campaign for a Healthier Oklahoma (PCHO), and Dr. Sara DePersio, PCHO Vice Chair.



(L) OSMA Executive Director Brian O. Foy (left) and Dr. Jay A. Gregory, OSMA member and President of the Oklahoma State Board of Health, check to make sure each legislator was scheduled to receive a visit from OSMA members during Medicine Day 2000.



(R) OSMA Vice President Dr. Gary F. Strebel (left) and Mrs. Strebel (Sherry) visit with one of their legislators, Rep. Leonard Hamilton, during the Medicine Day activities.



(L) Dr. David S. Russell (left), Chair of the OSMA Board of Trustees, and OSMA President Dr. Boyd O. Whitlock (right), visit with Rep. Curt Roggow, who represents Dr. Russell's home district. Drs. Russell and Whitlock were two of the more than 150 OSMA members, medical students, and spouses who attended Medicine Day 2000.



(R) Dr. Bruce L. Storms, Speaker of the OSMA House of Delegates, and Kathy Musson, OSMA Director of Governmental Activities, discuss legislative strategy during Medicine Day 2000.

Dextromethorphan Abuse on the Rise in Oklahoma

The Oklahoma Poison Control Center, a program of the University of Oklahoma College of Pharmacy and Children's Hospital of Oklahoma, has noted an alarming new drug abuse trend. Teenagers and young adults, mostly 13 to 19 years of age, are deliberately ingesting large amounts of Coricidin® HBP for Cough and Cold. Some take as many as 15 or more tablets at one time. The teenagers are seeking what they describe as an LSD-like "high" from dextromethorphan, a non-prescription cough suppressant. Most discovered the practice on the Internet or from friends at school.

Dextromethorphan abuse is not new. Large amounts of Robitussin®-DM and other similar dextromethorphan-containing liquids have been uncommonly abused for years. Most contain up to 15 mg of dextromethorphan per teaspoon. This new trend of Coricidin® abuse is an attempt to avoid drinking four to eight ounces or more of cough syrup at one time, a frequently nauseating experience.

Cases concerning abuse of dextromethorphan and specifically about Coricidin HBP® have been increasingly reported to the Oklahoma Poison Control Center between January 1 and February 14, 2000. Four of these cases were treated in hospitals. Reported symptoms included increased heart rate, elevated blood pressure, increased pupil size, drowsiness, dizziness, slurred speech, unsteady gait, hallucinations, confusion, and nystagmus (involuntary rapid, rhythmic movement of the eyeballs). Most other calls were from health professionals, school officials, and law enforcement seeking information about multiple cases of drug abuse or shoplifting of Coricidin®, or from parents who discovered that their children were abusing Coricidin® or other dextromethorphan-containing products.

The most common product involved in the current trend is Coricidin® HBP for Cough and Cold. The product contains 30 mg of dextromethorphan per tablet. It also contains 4 mg chlorpheniramine, an antihistamine, per tablet. As a result, anticholinergic toxicity may result from large ingestions. Signs and symptoms of anticholinergic toxicity include an increased heart rate, elevated blood pressure, elevated temperature, hallucinations or delirium, dry mouth, increased pupil size, and constipation. Large doses of dextromethorphan may cause hallucinations, confusion, excitation, increased or decreased pupil size, nystagmus, seizures, coma, and decreased breathing. An excessively large amount of either agent could be fatal.

An additional risk for teens is choosing the wrong Coricidin® product. Some of the other Coricidin® formulations include other ingredients such as acetaminophen (the active ingredient in Tylenol®) and/or phenylpropanolamine (a decongestant). Overdoses of acetaminophen can cause liver damage. Large doses of phenylpropanolamine are toxic to the heart and central nervous system.

Pharmacists, emergency department physicians, retailers, counselors, school nurses, teachers, and parents need to be aware of this new trend. Children should be warned that this drug abuse practice can be dangerous.

For further information, call Lee McGoodwin at the Oklahoma Poison Control Center at 800/764-7661.

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Reducing Teen Pregnancy in Oklahoma: Focusing on Older Teens (18-19 Years Old)

By Marilyn Lanphier, RN, MPH, FSAM, Adolescent Health Programs, Maternal and Child Health Service, Oklahoma State Department of Health; Sharon Rodine, MEd, Project Director, *HEART of OKC* Project (Healthy, Empowered, and Responsible Teens of OKC), Oklahoma Institute for Child Advocacy.

Not only does the United States have the highest teen birth rate of all the industrialized nations, our teen birth rate is nearly twice that of Great Britain and ten times that of Japan. The 1998 Oklahoma teen birth rate for females aged 15-19 is 64.3 per 1,000,[1] compared to the US rate of 51.1 per 1,000 births to females of the same age group.[1] Each year, births to older teens—18- and 19-year-olds—comprise approximately two-thirds of all teen births, both in our state (65%) and in the United States as a whole (63%).[2] To achieve any significant reduction in either teen birth rates and/or the sheer number of teens giving birth in Oklahoma, our state must address the issue of older teens. To date, however, limited attention, research, or program development has been focused on this part of the teen birth issue.

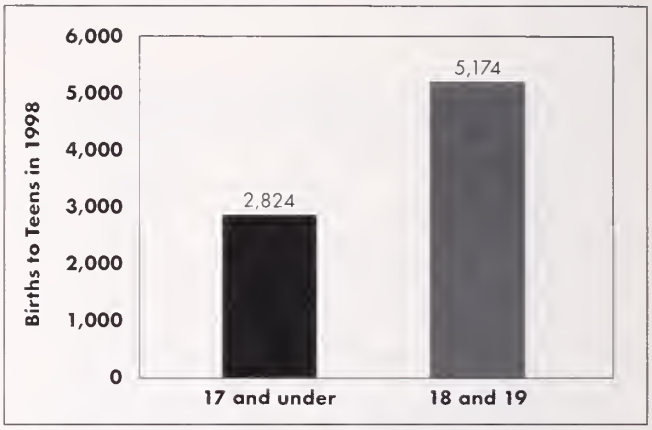


Figure 1. Births to Oklahoma Teens, 1998. From the Oklahoma State Department of Health.

An Oklahoma Snapshot

Of 1998 births to teens, 5,174 females aged 18-19 gave birth (65%), compared to 2,824 births to females aged 17 and under (35%) (Figure 1). Seventy-three percent (73%) of the births to 18- and 19-year-olds in Oklahoma in 1998 were births to first-time moms; 27% were subsequent births.[3] In some neighborhoods of our state's capital city, the birth rates to 18- and 19-year-olds are ***three to four times higher*** than the US rate. According to 1998 data, the highest birth rate for 18- and 19-year-olds in a single zip code area in Oklahoma City was 326 per 1,000 females.[4]

According to the Pregnancy Risk Assessment Monitoring Survey (PRAMS) data collected by the Oklahoma State Department of Health, pregnancy among older teens poses an array of serious issues when compared to women who postponed pregnancy until age 20 or older. When compared to mothers aged 20 years or older, teen mothers who were aged 18 and 19 years were:

- At least 1.48 times more likely to report a mistimed pregnancy.
- At least 1.57 times more likely to have a low birth weight baby.
- At least 1.73 times more likely to be unmarried at the time of conception.[5]
- At least 1.51 times more likely to be unmarried at the time of delivery.

When compared to mothers aged 25 years or older, teen mothers who were aged 18 and 19 years were:

- At least 1.70 times more likely to live below 100% of poverty.
- At least 1.91 times more likely to live at or 184% above poverty.
- At least 1.63 times more likely to have a very low birth weight baby than those mothers of ages 20 to 29.[5]

According to the PRAMS data, there was no significant difference in birth control use at the time of conception among mothers of any age. However, women aged 18 and 19, when compared to women aged 25 to 29, were more likely to report that they did not think they could get pregnant, or they did not want to use birth control, as reasons for not using birth control at the time of conception.[5]

Call to Action

According to the 2000 *State of the State's Health Report*, the issue of unwanted and unintended pregnancies is a critical health issue that must decrease if our state is to thrive economically. The report emphasizes that numerous studies have shown a strong association between income and poor health outcomes. Oklahoma ranks 45th out of the 50 states for personal income levels.[6] The report also indicates that over 32% (more than 76,000) of Oklahoma's children under age 5 live in poverty.[7] Many of those children would have been born to a mother who first gave birth as a teen.[8] Solutions identified in the report include decreasing unwanted and unintended pregnancies. The negative health and socioeconomic outcomes associated with unwanted and unintended pregnancies—including high rates of low-weight births, physical violence, and poverty—are unacceptable.

A New Partnership

The Adolescent Health Program of the Oklahoma State Department of Health, the *HEART of OKC* (Healthy, Empowered and Responsible Teens of OKC) Project of the Oklahoma Institute for Child Advocacy, and the Health Promotion Sciences Department of the College of Public Health, University of Oklahoma Health Sciences Center, are forming a partnership to begin addressing the issue of births to older teens in Oklahoma. Current data will be analyzed and additional data will be collected from the

older teen population during the coming year. National health and education organizations are being invited to provide technical assistance and support for this effort. State and local organizations in Oklahoma are invited to participate in this information-sharing effort. The goal of the partnership is to identify and initiate promising prevention messages and programs that are effective in reducing the birth rate to older teens.

Recommendations

A major recommendation for Oklahoma comes from the *State of the State's Health Report*: "The immediate implementation of a statewide initiative to reduce unwanted and unintended pregnancies, especially among teens, through appropriate, comprehensive educational and preventive measures. Funding for such a program should be similar to the successful Children First program, with the same commitment to quality, follow-up, and evaluation."[9]

Other actions that would support this overarching recommendation would include:

- Development of an accurate profile of older teens. (Who are they? Where are they? What prevention messages are most effective in reaching them? Which messengers are most effective in reaching them?)
- In-depth analysis of available data (PRAMS and other sources) and the collection of additional data from focus groups and other methods.
- Development of multiple, intentional strategies for reaching older teens at the local community level: 1) major emphasis on primary prevention, 2) prevention of pregnancy among sexually active older teens, and 3) services that will allow pregnant and parenting teens to finish high school, obtain additional training, and access health care services.

Summary

Births to females aged 18 and 19 account for two-thirds of teen births in Oklahoma annually. It is important for Oklahoma to identify effective ways to reduce births to this age group. Nationally and locally, there are few prevention programs and little data. Oklahoma has the opportunity to lead the nation in reducing births to older teens by aggressively addressing the issue, sharing promising approaches, and building prevention efforts that include older teens in meaningful ways.

For more information, contact Edd Rhoades, MD, Chief, Maternal and Child Health Service, or Marilyn Lanphier, Adolescent Health Programs, Maternal and Child Health Service, Oklahoma State Department of Health, 405/271-4470.

References

1. Oklahoma Vital Statistics, 1998, as quoted in *Teen Pregnancy Prevention—Facts About Oklahoma*, Maternal Child Health Service, Oklahoma State Department of Health, 2000, p. 6.
2. Moore K, et al. *Child Trends*, December 1999 and Oklahoma Vital Statistics, 1998, as quoted in *Teen Pregnancy Prevention—Facts About Oklahoma*, Maternal Child Health Service, Oklahoma State Department of Health, 2000, p. 2.
3. Assessment and Epidemiology Division, Maternal Child Health Service, Oklahoma State Department of Health, as quoted in *Teen Pregnancy Prevention—Facts About Oklahoma*, Maternal Child Health Service, Oklahoma State Department of Health, 2000.
4. Oklahoma Vital Statistics, 1998.
5. Oklahoma Pregnancy Risk Assessment Monitoring System, Assessment and Epidemiology Division, Maternal Child Health Service, Oklahoma State Department of Health.
6. United States Bureau of Economic Analysis, 1999, as quoted in *The State of the State's Health*, Oklahoma State Board of Health, 2000, p. 8.
7. United States Census Bureau, February 1999, as quoted in *The State of the State's Health*, Oklahoma State Board of Health, 2000, p. 8.
8. *The State of the State's Health*, Oklahoma State Board of Health, 2000, p. 13
9. *The State of the State's Health*, Oklahoma State Board of Health, 2000, p. 13-14.

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William G. McCreight, Sr., MD March 10
Armond H. Start, MD March 30
Billy E. Blevins, MD April 3

Obituaries

Armond H. Start, MD
1931-2000

Armond H. Start, MD, died March 30, 2000. Dr. Start was born May 2, 1931 in Grand Rapids, Mich. He received his medical degree from the University of Michigan in 1957, and served in the United States Air Force from 1958 to 1960. Dr. Start was a member of the Oklahoma State Medical Association.

Billy E. Blevins, MD
1931-2000

Billy E. Blevins, MD, died April 3, 2000. Born in Enid, Okla, on August 17, 1931, Dr. Blevins received his medical degree from the University of Oklahoma School of Medicine in 1960. He served two years (1953 to 1955) in the United States Army. Dr. Blevins was a life member of the Oklahoma State Medical Association.

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To the Editor:

I am responding to your editorial on de-unification. Your comments are interesting and thought-provoking, but I wonder about your comment regarding the check you write and your comment that "you might call it a habit."

Unfortunately I believe your habit of writing a check, and me being forced to write the check, often results in the AMA taking Oklahoma and its delegates for granted. I wonder if we wouldn't get more attention if there were no members of the AMA from Oklahoma—if our concerns and proposals might not then get a great deal of attention both from the AMA and the national media?

I have written many times to the President of the American Medical Association and the various committees of the AMA, particularly those responsible for CPT coding blunders and especially the implementation of the so-called Correct Coding Initiative. I have essentially gotten no response from anyone. I have pointed out a number of inequities in the Medicare system and asked for assistance from the AMA in correcting some of these problems, again with no help from anyone at the AMA.

I believe Oklahoma would be better served with a "right to work law," and therefore I believe membership in the American Medical Association should be voluntary. If they represent me well, and respond in what I consider a reasonable manner to my request and I see efforts to make changes that will be beneficial to all physicians, I would be happy to belong to the American Medical Association. As the Association currently stands, I do not believe I would wish to be a member. I would be in favor of belonging to the Oklahoma State Medical Association because I believe they have been responsive to the welfare of Oklahoma physicians.

An example of what I consider to be most unfair to Oklahoma physicians is tying of Medicare reimbursement to practice costs, and the great differential of payment between Oklahoma and other areas, such as Detroit. For example, the malpractice differential for Detroit versus Oklahoma is, as I understand it, a factor of 6. Why should Oklahoma physicians be penalized in their reimbursement from Medicare for having an efficient liability insurance program and for having physicians who practice good medicine and who are seldom sued for malpractice? Since Medicare is a tax-supported system and the tax rate in Oklahoma is the same as that in Detroit, New York, California, Florida, etc., I believe the compensation should be equal in all areas of the country.

Another point with which I have a strong disagreement is HCFA's regulation against physicians being paid for treatment of family members. This includes in their definition of family members uncles, aunts, cousins, brothers, sisters, sisters-in-law, etc., etc., and I strongly believe this is unfair both to our families and to physicians, both of whom have paid their taxes for malpractice, and most of us have paid much more than our share. I believe no regulation should prevent me from treating any of my relatives who have Medicare and being compensated in a normal fashion. There are many regulations against over-charging or any form of fraudulent billing and I do not believe this regulation against treatment of relatives is reasonable.

The AMA also has stated that they feel it is unethical for a physician to treat a family member. I do not believe the majority of Oklahoma physicians agree with this and I would doubt that the majority of physicians in the United States agree with this, nor would they vote for such a ruling if allowed to do so. I believe the individual physician is the best judge of whether or not he or she is the proper physician to treat his or her relatives or not, or whether or not he or she should refer his or her relatives elsewhere. Along with this is our Board's ruling against prescribing controlled substances for family members. Again, I do not feel this is a rule that is needed, and in fact, I believe it is counterproductive to good medicine. If my brother-in-law, sister-in-law, cousin, uncle, aunt, sister, etc., has a skin lesion which he or she wishes removed, and he or she requests me to perform the surgery and I feel it is within my ability to perform the procedure that he or she requests, I do not feel it should be unethical, unlawful, or in any way prohibited. Along with this, I believe I should be able to prescribe them the normal medications that I feel are indicated, including antibiotics and/or the normal medications which I usually prescribe for postoperative pain. We already have on our Oklahoma statutes adequate protection for physicians who mis-prescribe, over-prescribe, or otherwise abuse the right to prescribe controlled substances, and I do not believe it serves anyone's best interest to prohibit a physician from rendering treatment to an individual simply because there is a kinship which any organization feels should change the normal doctor-patient relationship.

These are but a few of the issues that I feel have not been adequately addressed by the American Medical Association, and in some cases, the Oklahoma State Medical Association and our Board.

It's my opinion that if I had the ability to withdraw my membership, perhaps my voice could have a greater impact than when I am essentially forced to belong to all three organizations.

Joseph W. Hayhurst, MD
Oklahoma City

Oklahoma State Medical Association

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May 5, 26	Tumor Board	7:00am	1 hr ea
May 6	"Situation Awareness-Your Key to Improving Care While Managing Risk"	8:00am	8 hours
May 8	"Sphincter Sparing Surgery for Rectal Cancer"	7:00am	1 hour
May 12	Cancer Conference	7:00am	1 hour
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May 16	Ophthalmology Dept. "Vertical Diplopia"	Noon	1 hour
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May 17	"Ethics For Lunch"	Noon	1 hour
May 18	National Quality Improvement Projects	12:15pm	1 hour
May 25	"Cerebrovascular Complications & Prevention of Stroke"	12:15pm	1 hour

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May 1, 8	Medicine Grand Rounds: "Chemical Dependency," "Future Fortunes Financial Outlook For America's Hospitals and Health Systems"	8:00am	1 hour
May 4, 18	Cancer Care Presentations-TBA	7:00am	1 hour
May 11	Cancer Inst. Oncology Grand Rounds-TBA	7:00am	1 hour
May 18	Stroke Conference: "CVA Y2K: Stroke Management Upgrade"	8:00am	1 hour

St. John Medical Center: Gail Hilst-918/744-2875

May 4	Critical Care Conf. "Trauma 1"	Noon	1 hour
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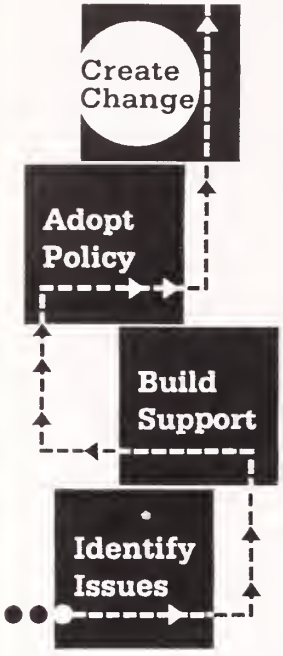
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- **Identify issues** of critical importance to medical staffs, such as on-call emergency coverage and EMTALA guidelines, scope of practice, "exclusive credentialing," HCFA regulations, and medical errors;
- **Build support** for these issues through educational programs, special issue forums, state and regional caucuses, reference committee hearings, the OMSS Assembly, and the AMA House of Delegates; and
- Persuade the AMA to **adopt policy** that will further the needs and concerns of medical staffs; so as to
- **Create change** at various levels within the public and private sector in an effort to improve the quality and delivery of medical care and the professional and personal success of physicians

Elect a member of your medical staff to serve as an OMSS representative* and attend the **2000 Annual AMA OMSS Assembly Meeting**. Topics for educational programs include:

- communication basics, team building and problem-solving
- on-call emergency coverage and EMTALA compliance
- scope of practice
- medical staff bylaws and the changing environment
- building "win-win" relationships between medical staffs and hospital/IDS administration
- status of legislative initiatives
- medical errors
- the impact of MCO insolvency on physician practice

For more information on how to register, call 800 262-3211 and ask for the Department of Organized Medical Staff Services or e-mail us at **omss@ama-assn.org**

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The More Things Change, the More They Stay the Same

We are all aware of the changing demographics in medical schools. Women are entering the practice of medicine at nearly the same rate as men, and there are many two-physician families. How can we accommodate the increasingly diverse population of potential members? We are challenged to find meeting times and places to attract our working members and program topics that will interest people of all ages, both sexes, and from many backgrounds and cultures. As I have met Alliance members from diverse backgrounds, I notice how much we have in common, not how different we are.



Mary Ann Couch, OSMA Alliance President

The same common interests that have brought us together as a body still prevail. First, we enjoy the camaraderie of others who are married to physicians. As we move to further educational opportunities or to new employment, the Alliance will be waiting for us. The people may be different, but it will be the same Alliance. We all suffer through calls in the night, aggravations with insurance companies who resist paying for services rendered, and the misapprehensions of strangers of "how wonderful it must be to be married to a doctor." We share stories of medical school or residency years, difficulties of solo practice, and difficulties of group practice. I learned much from listening to those who were retiring from practice at the time we were just beginning. I hope someone will want to listen to my stories in a few years when I am ready to look back on my own "good old days."

We also share a concern for health care in our communities. The SAVE program has led to many projects suiting our local needs. Wherever we live there are people that need and deserve our concern and our efforts to improve their lives. Whether we raise money to fund a new building or simply gather toiletries for women and children who flee to a safe shelter, we can make a difference in someone's life. We can distribute the excellent educational materials developed by the AMAA, or organize a seminar to combat unhealthy lifestyle choices. We often are privy to information that makes it possible for us to "get the job done." And, increasingly, we have the variety of skills and training needed for accomplishing whatever goal we set for ourselves as a group. I anticipate that our partnership with the OSMA will further the aims of the Physicians' Campaign for a Healthier Oklahoma this year. We will make use of many of our skills and no doubt develop new ones. I look forward to hearing of the programs and projects across the state.

A third shared concern is medical education. The AMA Foundation has facilitated the process of giving support to medical schools and medical students. The students of today will be caring for us in the future, so we have a stake in their future. We have contributed a broad base of support for medical education through our Sharing Cards, basket auctions, "Doctor and Doll" cards, memorials, and other fundraising efforts. We are also interested in spouses of medical students and residents as they too are part of our future. We attempt to reach them through a variety of programs, and ask other members to "Sponsor a Spouse" so they can join OSMAA and AMAA at no cost.

We all are concerned about the future, and legislation currently under consideration will affect the physician's ability to care for patients. The Alliance has long been involved in educational and lobbying efforts in support of medicine. Our legislative coffees and participation in Medicine Day at the Capitol are examples, as are our donations to OMPAC and AMPAC. It is important to let our representatives know our "side of the story," and we can speak more loudly as an organized group than we can alone.

If you are not a member of OSMAA, please join us and share some fun as we make a difference together. To quote Aesop: "Union gives strength." What was true in 550 BC is true today.

"We are challenged to find meeting times and places to attract our working members and program topics that will interest people of all ages, both sexes, and from many different backgrounds and cultures."

The Last Word

When a Simple Reminder Can Save a Life...

A recent survey conducted by the Gallup Organization for the College of American Pathologists (CAP) reveals that women who receive a reminder from their doctor are much more likely to schedule their annual Pap smear (78%) than those who do not get reminded (47%). Sixty-two percent of those who did not receive a reminder felt they would be more likely to make an appointment if they were reminded. Women who say their primary care provider is an OB/GYN are more likely than others to report getting a reminder about their Pap smear, a test that is credited with decreasing mortality rates from cervical cancer by 70%.

—from AMA/Federation News, March 29, 2000

AMA Guide on Dementia Now Available

"Diagnosis, Management, and Treatment of Dementia: A Practical Guide for Primary Care Physicians," is now available from the American Medical Association (AMA). Cost is $5 ($3 for AMA members) per single copy, or 25 copies for $100. For more information or to order, call the AMA at 312/464-5563.

Big Tobacco Targets Women

Philip Morris recently launched a new advertising campaign urging women to "Find your voice." In response, SmokeLess States, the Robert Wood Johnson Foundation anti-tobacco initiative administered by the AMA, is encouraging women to reject the slick and misleading advertisements that appear to be specifically targeted to Latina, African-American, and Asian-American women. Noting that more than 140,000 women die each year of smoking-related diseases, SmokeLess States believes the campaign is designed to encourage women to take up a behavior that results in death.

—from AMA/Federation News, March 29, 2000

AAP Releases Revised Periodicity Schedule

The American Academy of Pediatrics has released its newly revised periodicity schedule, "Recommendations for Preventive Pediatric Care," which updates the 1995 schedule and provides guidelines on procedures and screenings necessary for children at various stages throughout their growth and development. See the Academy's Web site, www.aap.org, for a complete list of AAP's policy statements.

A Notice From the Board of Medical Licensure...

Every year the Oklahoma State Board of Medical Licensure and Supervision (OSBMLS) gets phone calls and letters from physicians who have failed to renew their license by the due date. Many have very legitimate reasons for missing the date, but are upset to learn that they owe an additional $125 late fee that cannot be waived.

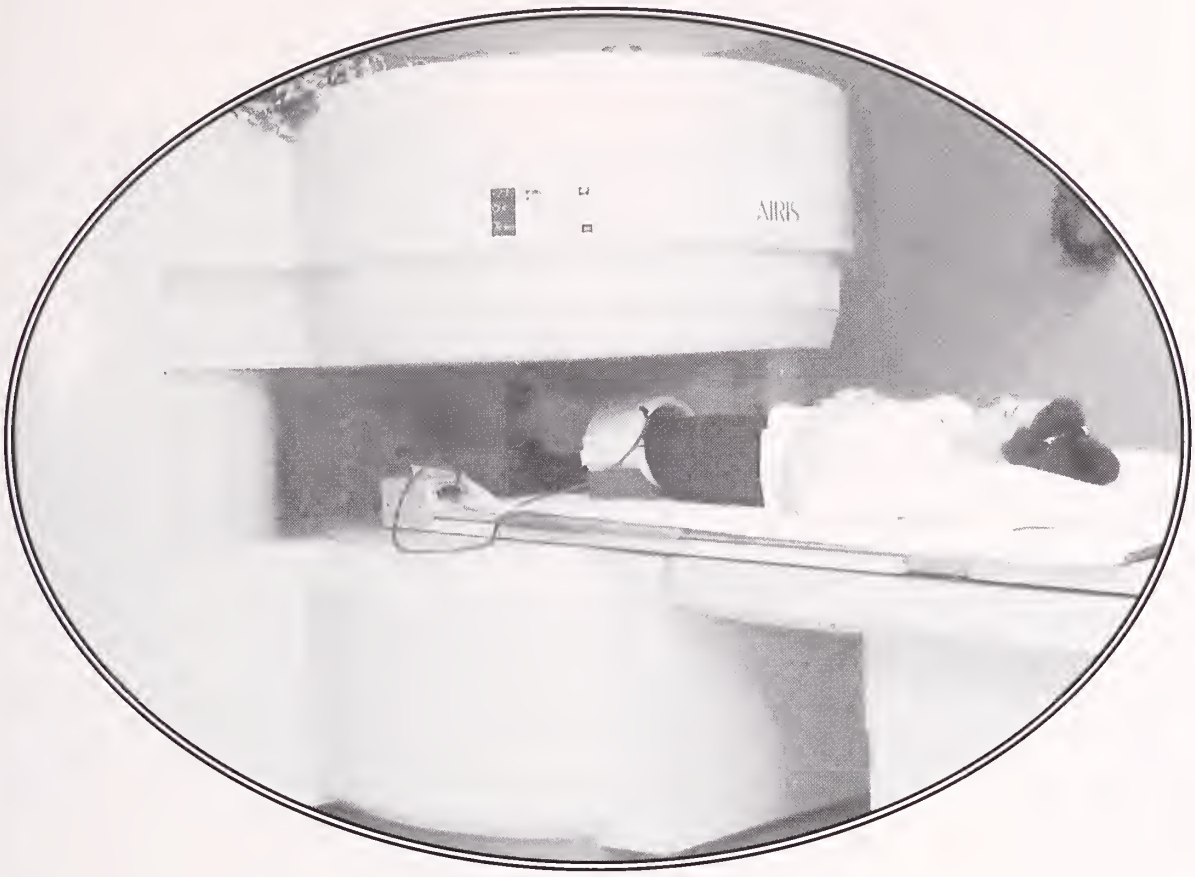
Outlined below is a summary of the renewal process:

- The renewal reminder and form are sent to the most current mailing address in the physician's file approximately two months in advance of the renewal due date. For this reason, OSBMLS should be notified of any change in practice or mailing address.
- In order to avoid the late fee, the renewal form must be postmarked on or before the 1st day of the renewal month. Renewals received on the 2nd day of the month are considered late and will be assessed a late fee.
- Physicians whose renewals are received on the 2nd day of the month will be notified that the license is temporarily suspended until the late fee is received, no later than sixty (60) days from the due date. It is important to note that the license is technically inactive during this time until the total fee of $275 ($150 renewal fee + $125 late fee) is received.
- If the license is not renewed within sixty days of the due date, the physician has to go through the complete reinstatement process as a new license application, with a fee of $400. This can often be a lengthy procedure, and the license is suspended during the reinstatement process.

In summary, the Medical Practice Act is very specific that a physician can renew their license at any time before the due date, up to the day the license is due. After the due date, the license is in suspension and the physician is practicing without a valid Oklahoma medical license. The physician has sixty days to complete the renewal form and pay the renewal fee of $150 plus the $125 late fee to renew their license.

This information is provided to inform physicians of the process that must occur to renew their license early. If you have any questions, please contact Robyn Kemp, Director of Licensing, OSBMLS at 405/848-6841.

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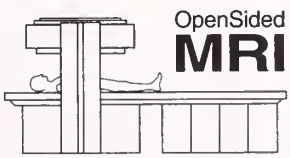
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JOURNAL

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INSIDE:

61-Year-Old Man
231

Drug-Seeking Behavior
242

Effects of Smoking on Health Care Costs
245

News
253

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EDITORIAL

Cynicism and Strawberries 227
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE

An Alliance of Strength and Unity 229
ROBERT J. WEEDN, MD, DUNCAN

SCIENTIFIC

61-Year-Old Man with Midsternal Chest Pain, Mid-Back Pain, and Lower Extremity Weakness: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine 231
MASATOSHI KIDA, MD, BURLINGTON, VT; C.A. SIVARAM, MD, OKLAHOMA CITY; NAJWA BAHU, MD, OKLAHOMA CITY; MAX WALTER, MD, OKLAHOMA CITY

COMMENTARY

Drug Seeking Behavior—A Differential Approach 242
WILLIAM H. YARBOROUGH, MD, TULSA

SPECIAL

Effects of Smoking on Health Care Costs 245
AMBIKA K. NAIR, MBBS, OKLAHOMA CITY; EDWARD N. BRANDT, JR., MD, PHD, OKLAHOMA CITY

NEWS

Paddack Takes Office as National President, 253...Pelofsky to Lead National Association, 253...OSMA Convenes 94th Annual Meeting at The Westin, 254

DEPARTMENTS

From the Oklahoma State Department of Health, 256...Letters to the Editor, 257...Obituaries, 259...In Memoriam, 259...CME, 262...Alliance, 263...The Last Word, 264

ABOUT THE COVER

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Cynicism and Strawberries

I must admit, I have become quite cynical about medical students and residents.

This is a dangerous position for me, as I am responsible for teaching these groups of learners. Like many of you, I practice my profession in the shadow of the Hippocratic Oath and sense that I am duty-bound to teach my profession to medical learners:

"...that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine...."[1]



And yet, I am still growing cynical and a bit disillusioned.

I am a bit embarrassed to confess this in such an open forum. I suspect that my department chair and dean will read this and my job will be at risk. I am a bit embarrassed to articulate my reason for cynicism. The articulation sounds so trivial and self-serving, and I hear echoes of the physicians who trained me in the articulation...but I am fatigued with looking over my shoulder and wondering who will be delivering care and practicing the "art" of medicine in the future.

About the time that I am ready to give up on the process, something turns my head and focuses me back to reality. With my cynicism "du jour" I have been exposed to experiences that need to be shared, that need to be held out as proof that there is a future generation of physicians who will carry on the traditions that you and I have been taught.

Recently, students from the OU College of Medicine were honored at an awards banquet for volunteer service. I still don't know why I was invited to the evening, but as the topic looked interesting to me, I signed up to have dinner with the group. I must confess that I really wanted to see if it were so. Are there still students who believe in volunteerism? Are there still medical students who can squeeze an evening in here or there—to help out at the local free clinic, or organize a blood drive, or provide educational assistance for a community clinic?

The conversation between the medical students at my table centered around how much their volunteer experience had enriched their lives and how they had enjoyed the experience. Several discussed how they had improved performance on tests by what they had seen at the community clinic. They were ready for further experiences.

I noted the excitement in their voices and found it refreshing. I began to reclaim my hope for the future of our profession, at least here in Oklahoma. The evening was full of examples of how medical students have met the needs of our communities with volunteerism and ingenuity.

Then a couple of weeks later, during weekend rounds, I am visiting with one of my inpatients. Bob has been an extremely ill-humored patient over the years—never seeming to be satisfied with my care, always frustrated that his worsening congestive heart failure is placing more and more limitations on his lifestyle and activity. Over the last few months he has had multiple admissions. He has progressed to the point that he is not eating. As I sit by his bedside discussing his lack of adequate nutrition, he looks through me and gives me the "why don't you just leave me alone" look.

After my bedside talk, my medical student and I talk about the importance of trying to encourage these folks, even when you get the impression that they are not interested. We talk about the more technical portions of caring for end-stage CHF. And we go on with our rounds.

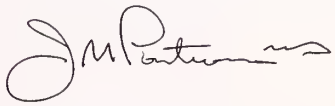
The next morning I go into Bob's room. He is much more animated and articulated than he has been for many weeks. I must have appeared a bit surprised during my interview and exam. Bob told me a story that caused me to stop in my tracks. It appears that my medical student had gone back to check on him later Saturday afternoon. In passing, he asked Bob what he craved. My patient told the student that strawberries and ice cream sounded pretty good.

Bob told me that 45 minutes later, fresh strawberries and one of those little cups of ice cream showed up in the hands of the medical student.

As he told me the story he said, "Can you believe that that young man took the time to help a cranky old man like me?"

I am a bit embarrassed that it takes actions like this to shake me out of my cynicism. Next time you come across a medical student, take the time to encourage them; take the time to look into the face and heart of Oklahoma Medicine for the next generation.

I bet you are going to like what you see.



J. Michael Pontious, MD
Editor-in-Chief

"Next time you come across a medical student, take the time to encourage them; take the time to look into the face and heart of Oklahoma Medicine for the next generation."

1. Hippocrates. *Works*. Adams F, trans. New York, NY: Loeb; 299-301.

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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President's Page

An Alliance of Strength and Unity

Congratulations to Susan Paddack of Ada, the new President of the AMA Alliance. Susan's election to this prestigious office is a well-deserved honor and one that brings credit upon all of us in Oklahoma. Susan is only the second Oklahoman to be accorded this honor; the first being Sherry Strebel, who served in 1991-92.



A former president of the Pontotoc-Johnston County and Oklahoma State Medical Association Alliances, Susan has also distinguished herself through her service in multiple leadership roles in the AMAA enroute to her selection as AMAA president. In honoring Susan, we also honor the commitment of our own OSMA Alliance and that of county medical society Alliances throughout the state that partner with us to meet our individual goals as physicians and the collective goals of our professional associations and societies.

My appreciation of the critically important work of the OSMA Alliance began with my wife Julie's participation in the OSMA Alliance, ultimately leading to her election as president of that organization in 1987-88. As a matter of fact, it was Julie's involvement with the Alliance that got me interested in the OSMA.

Not only do Alliance members partner with us as our spouses in everyday life, but the Alliance's work promotes and supports the profession of medicine as we face the challenges of change in a very complementary way.

The OSMA Alliance's focus is on promoting public health, ensuring sound health care legislation, raising funds for medical education, and membership development. On the national level, the AMAA's award-winning S.A.V.E (Stop America's Violence Everywhere) initiative and the anti-smoking project utilizing the Extinguisher, the superhero character so popular with elementary school children, are just two examples of the many successful projects that group has undertaken.

Our Alliance is frequently doing better for us than we are doing for ourselves in these areas outside the direct practice of medicine, especially at the grassroots level—in the counties and communities where many projects have been carried out over the years—and serve as models for the future in the AMAA Project Bank: The Encyclopedia of Public Health and Community Projects.

New OSMA Alliance President Mary Ann Couch, from Muskogee, has chosen "Strength in Unity" as the theme of her presidency year as her members work to achieve the following goals:

1) to assist the OSMA in its program to improve the quality of life through health education and services; and

2) to coordinate and advise constituent auxiliary/alliances concerning their programs and activities.

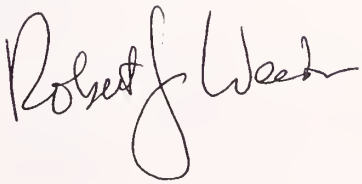
In this regard the Alliance will play a pivotal role in the Physicians' Campaign for a Healthier Oklahoma. As Mary Ann and Alliance members throughout the state work diligently to support us as physician spouses, we must in turn learn more about and support their endeavors.

The Alliance membership is less than a fourth of the numbers of the OSMA membership, but with a thousand members they do the work of many more and could do yet more if we physicians encouraged and supported all of our spouses to join and participate in the Alliance at all levels—county, state, and national.

Mary Ann and I, in addition to being mutually supportive, have developed a common and very ambitious goal for our organizations: ***To have 2001 people at the Capitol on Medicine Day 2001.***

By working together, we can not only double the effort, but that effort will be compounded even further to produce an exponential influence and force on behalf of our patients and our profession—and it will be good medicine.

A most sincere and heartfelt thanks go to all of our hardworking Alliance partners. I wish you and your Alliance partner well.



Robert J. Weedn, MD
OSMA President

"By working together, we can not only double the effort, but that effort will be compounded even further to produce an exponential influence and force on behalf of our patients and our profession–and it will be good medicine."

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61-Year-Old Man With Midsternal Chest Pain, Mid-Back Pain, and Lower Extremity Weakness: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine

Masatoshi Kida, MD; C.A. Sivaram, MD; Najwa Bahu, MD; Max Walter, MD

Case Presentation

Najwa Bahu, MD

Today we will be presenting the case of a 61-year-old male who noted the onset of dull midsternal chest pain on the morning of his admission. He described the pain to be associated with sudden onset of mid-back pain and weakness of both of his lower extremities. He went to the emergency room closest to his home.

At the time he was treated for a supraventricular tachycardia, with a reported heart rate of 150 beats per minute. He was given calcium channel blockers and beta blockers. While he was at that hospital, he underwent a CT scan of his abdomen to rule out a leaking abdominal aortic aneurysm. After the CT scan was read (reportedly negative except for a renal mass) he was transferred to University Hospital.

Upon arrival at University Hospital emergency room, the nurses' notes described him as pale, with the presence of circumoral and peripheral cyanosis; he was also noted to be lethargic. On initial presentation he was normotensive with the development of transient hypotension, which was attributed to medication he received at the previous emergency room. He was treated with naloxone for this hypotension.

Past medical history is significant for spinocerebral deterioration, reportedly diagnosed back in 1940. He also had cervical spine stenosis without a history of cord compression. He has COPD and type II diabetes during times of stress. In 1996 he had a myocardial infarction, which was proven by CPK changes. He underwent left heart catheterization, which demonstrated a co-dominant right coronary artery. He had no significant coronary artery disease. The ejection fraction was 50% to 55%. Mild left ventricular enlargement was noted, as well as changes consistent with an apical infarct, and mild elevation of the left ventricular end diastolic pressure. He also has a significant tobacco use history, smoking a pack a day for about 20 years. The quit date is 2 years prior to his presentation.

He denied taking any medications at the time of presentation. His blood pressure ranges in the emergency room were systolic 90-132, diastolic 60-96. His heart rate was 104-135, temperature is afebrile, and his respiratory rate was 36.

Physical Exam: He had no jugular venous distension; lung exam was significant for a few crackles on the right with ronchi and mild crackles on the left. He was noted to be using accessory muscles to breathe. Cardiovascularly, a 2 out of 6 systolic ejection murmur at the left sternal border was described with no further description.

Extremities: He had no cyanosis/clubbing/edema. His pulses were adequate. His reflexes in his lower extremities were diminished, as well as his strength and sensation. That was the extent of his neurologic exam.

Labs: Urine drug screen specific for salicylates, sympathomimetic amines, nicotine, caffeine, chlorpheniramine, and diltiazem.

While he was in the emergency department he underwent an ultrasound of the abdominal aorta to again rule out the leaking abdominal

Direct correspondence to: Roger A. Brumback, MD, Department of Pathology, BMSB-451, University of Oklahoma Health Sciences Center, 940 Stanton L. Young Boulevard, Oklahoma City, OK 73104

Table 1. Summary of Radiology Examinations for the Patient

10/10/96 MRI C-Spine: Cervical card atraphy and acquired stenasis C3-C4. Cerebellar atrophy?
11/5/97 CT Abd & Pel: Narmal XC far small renal cyst.
11/6/97 US Kidneys: R. Suprarenal mass 3.1 X 3.2 X 3.4 cm.
12/5/97 BAE: Narmal
12/13/97 CT Head: Narmal.
12/15/97 CT Abd & Pel: Narmal Suprarenal mass Decreased attenuation L. renal vein.
12/17/97 Chest PA & Lat: Emphysema & COPD.



Figure 1. This T2 weighted sagittal MRI image of the cervical spine October 10, 1996 demonstrates atrophy of the spinal cord and cerebellum and acquired stenosis at C3–C4.

aneurysm, the results of which were negative for free fluid around the aorta or evidence for an aneurysm. He was admitted to our cardiology service where he underwent an echocardiogram (left ventricular enlargement, left ventricular ejection fraction was 25% to 30%. He had some right wall motion abnormalities and a left ventricular thrombus).

EKG at the time of admission into the emergency room: He was eventually ruled in for a non Q wave MI established by cardiac isoenzymes. He was treated with nitrates, ACE inhibitors, and anti-coagulation. His recovery was uneventful. His possible pneumonia was treated with erythromycin and ceftriaxone.

By the second hospital day his symptoms began to resolve. His tachycardia subsided, he remained normotensive, and all cultures were negative. He underwent a repeat heart cath which confirmed the right dominant system. It confirmed the absence of significant coronary artery disease, and also the presence of the left ventricular thrombus.

The report of the renal mass, which was noted at the outside hospital, was further worked up at University Hospital. They repeated a CT scan, the results of which prompted the acquisition of an ultrasound, and the ultrasound led to the patient being preadmitted for further diagnostic tests.

Question: Najwa, do you have a blood pressure from the other hospital before he was treated? He got calcium channel blockers and beta blockers.
Dr. Bahu: No, I don't have a blood pressure from the other hospital.

Question: What happened to his lactic acidosis?
Dr. Bahu: Everything resolved. By the second hospital day, all of his acidosis, everything had resolved. By the fourth hospital day he was completely back to baseline.

Radiology Presentation
Max Walter, MD

Table 1 is a summary of the radiology examinations available for this patient. On October 10, 1996, an MRI of the neck was performed for lower extremity weakness of 14 years duration and some neck pain. This examination demonstrates a generalized atrophy of the spinal cord and acquired spinal stenosis at C3-4. There is also mild atrophy of the cerebellum (Figure 1). On November 5, 1997, at University Hospital, a CECT of the abdomen and pelvis was done for a possible kidney mass. Although initially interpreted as normal except for a small renal cyst, further review of the images reveals an enlarged right adrenal gland with patchy rim enhancement (Figure 2). The HU (Hounsfield number) number is 74, indicating that the mass is accumulating radiographic contrast media. The next

day, November 6, 1997, an ultrasound examination demonstrated a right suprarenal 3 cm mass. A barium enema performed on December 5, 1997, was normal. An NCCT of the head, December 13, 1997, demonstrated mild cerebral and cerebellar atrophy and an old small left thalamic infarct. The presence of a right adrenal mass was confirmed by a repeat NCCT and CECT of the abdomen on December 15, 1997. The right adrenal mass has not changed in size or appearance during the five weeks since the previous examination (Figure 3). It remains egg-shaped, sharply marginated, and measures 3 cm × 3 cm × 4 cm. The non-contrast HU numbers of the mass were between 25 and 30, too high for a simple benign adenoma. There was no calcification. During contrast infusion the right adrenal mass displayed early enhancement with a mean HU number of 69 (Figure 4). The left adrenal gland enhanced normally. At equilibration the mean HU number was 82. The left renal vein was narrow and the IVC small, findings suggestive of reduced intravascular volume (Figure 5).

The differential diagnosis of an adrenal mass by CT is simple (Table 2). There are general guidelines to determine whether a lesion is a benign adrenal adenoma or something that requires further workup (Table 3). If an adrenal lesion is less than 5 cm, if it is smoothly marginated, if it has a low density and uniform low absorption, and if the non-contrast Hounsfield number is 13 or less, it is probably a benign incidental adrenal adenoma, and it can be safely ignored.[1] This finding is believed 100 percent specific. If only a contrast CT is available, then the HU number measurements need to be made on images obtained at equilibration of the IV contrast (about 15 minutes after the infusion of the contrast media). At contrast equilibration, 26 HU or less has about the same significance as 13 HU or less on the NECT. The HU numbers of this patient's mass exclude benign adrenal adenoma. A myolipoma is a very fatty tumor easily identified by inspection alone. There is no fat in this adrenal mass. A Cohn's adenoma can be 1 cm to 3 cm in size, usually is sharply marginated, and may enhance on CT. This lesion is larger than most Cohn's adenomas. A Cushing's adenoma may be low or mixed density, is often larger than a benign adenoma, and may or may not enhance. The history and physical findings exclude Cushing's adenoma in this patient. Pheochromocytoma runs a gamut of appearances from non-enhancement to strong enhancement. It is usually sharply marginated, and 5 cm or less in size. It may enhance as strongly as a paraganglioma. Carcinoma of the adrenal gland is usually larger than 5 cm at presentation, shows aggressive features, and may not have uniform enhancement. A metastatic adrenal tumor is unlikely if

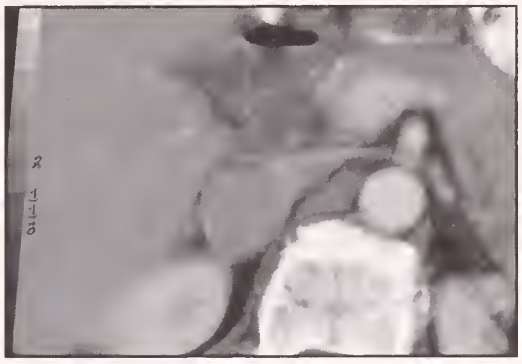


Figure 2. Image from CECT of abdomen November 5, 1997 demonstrates weakly enhancing sharply marginated right adrenal mass.



Figure 3. Image from NCCT December 15, 1997 confirms the right adrenal mass. The mean HU number of the mass was 27 on this image.



Figure 4. Image from CECT of abdomen December 15, 1997 confirms enhancement of the right adrenal mass. The mean HU number is 69.

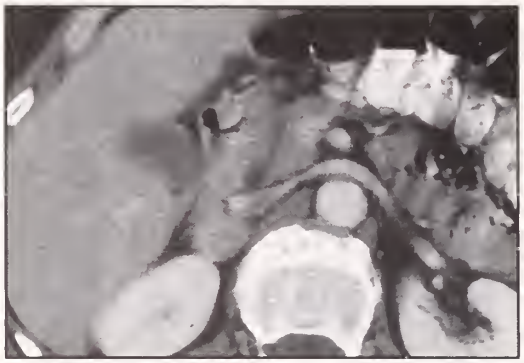


Figure 5. Image fram the CECT of abdomen December 15, 1997 demanstrates the small caliber af the IVC and left renal vein.

Table 2. The Differential Diagnasis af Isalated Adrenal Masses
Myelalipama
Cahn's Adenama
Cushing's Adenama
Pheachramacytama
Carcinama
Metastatic Tumor
Benign Adenama
Adrenal Hemmarrhage

Table 3. The Features of Benign Adrenal Adenoma[1]
Size less than 5 cm.
Smaathly marginated with easily perceived interface af separatian fram adjacent structures.
Unifarm law absarptian af radiatian (law density).
Nan-cantrast CT Haunsfield number less than 10. Sensitivity 87%; Specificity 100%.
5-15 min. after cantrast CT Haunsfield number less than 26. Sensitivity 92-100%; Specificity 94%.
Karabkin, Bradeur, et al, AJR 1998;170:747-752.

there is no known primary ncoplasm. Adrenal hemorrhage usually appears cystic with contrast enhancement.

Discussion

C.A. Sivaram, MD

This patient had findings attributable to multiple systems. Let us consider them systematically to help in the analysis of this diagnosis.

Cardiovascular: There was history of chest and mid-back pain at the time of hospitalization. In addition, he had a narrow QRS complex tachycardia that required therapy. While being hospitalized he had sinus tachycardia and several readings of diastolic hypertension. His EKG showed inferior and possibly anteroseptal infarctions. Cardiac enzymes revealed myocardial necrosis with elevation of both MB fraction and troponin, suggesting an acute myocardial event. Echocardiogram showed dilated LV with depressed LV function, and regional wall motion abnormalities consistent with ischemic heart disease. However, cardiac cath failed to reveal significant coronary artery occlusions. The findings on cardiac cath were unchanged compared to 1996 with the exception of apparent decline in LV function over the intervening 2 to 3 years. The above clinical findings are indicative of myocardial ischemia due to non-atherosclerotic coronary heart disease.

Neurological: There was a long history of spinocerebellar degeneration. We do not have details of all the diagnostic studies performed to confirm this diagnosis. There is no information given to us on family history of neurological diseases. Physical exam showed hyporeflexia of lower extremities and abnormal sensations in the lower extremities. It is not clear which modalities of sensations were affected. In addition to spinocerebellar degeneration, he also had a diagnosis of cervical stenosis.

Pulmonary: Chest x-ray of this man, a chronic smoker, was abnormal with dominant findings in the right lower lung field thought to be due to either congestive heart failure or pneumonic process. There was leukocytosis with left shift on admission, resolving after treatment with erythromycin and ceftriaxone. Clubbing of the fingers was absent.

Suprarenal and Renal: Imaging studies revealed a mass 3 to 3.5 cm in the right suprarenal area, as well as a hypodense cortical lesion in the right kidney. Urinalysis showed 2+ proteinuria; we do not have 24-hour estimation of urinary proteins or serum albumin levels.

Laboratory and Metabolic: Lactic acid levels were elevated on admission with high anion gap, the latter resolving by the fourth day. Ketones were negative while blood glucose was elevated.

I shall try first to see if all or many of these findings could be unified in a single diagnosis. Occurrence of myocardial infarction without significant coronary obstruction was seen in

this patient. This finding is not totally unusual since most patients presenting with acute MI and ST elevation do not show significant residual stenosis of the infarct-related artery. Plaque rupture often occurs in a non-flow limiting stenosis. However, there are several causes of myocardial infarction in the absence of severe obstructive coronary artery disease (Table 4).

Myocardial dysfunction due to ischemia occurring in absence of coronary arterial stenosis in a patient with a suprarenal mass is consistent with the possibility of pheochromocytoma. Several clinical features seen in this patient could be seen in pheochromocytoma–tachycardia, hyperglycemia, episodes of hypotension, evidence of volume contraction (Hb 16.9 on admission), and pallor (due to vasoconstriction induced by catecholamines). Focal myocarditis has been described in patients with pheochromocytoma, as well as in experimental studies after administration of norepinephrine and epinephrine.[2]

The diagnosis of pheochromocytoma is established using laboratory studies (estimation of urinary and plasma catecholamines or their metabolites) (Table 5). We have not been provided data about any functional biochemical tests. Imaging studies in pheochromocytoma have predominantly the role of localizing the tumor. Needle aspirations or biopsies are contraindicated in pheochromocytoma because of the risks of hypertensive crisis during the procedure. Pheochromocytomas have been associated with cerebellar syndrome in von Hippel-Lindau disease,[3,4] where retinal hemangioblastoma, cerebellar hemangioblastoma, and spinal cord hemangioblastoma occur. If von Hippel-Lindau disease was the final diagnosis, myocardial ischemia and heart failure were presumably caused by increased catecholamine levels from a functioning adrenal tumor. Absence of family history consistent with autosomal dominant inheritance, ocular symptoms, and paucity of neuroimaging studies make it difficult to be certain about the diagnosis of von Hippel-Lindau disease. Occasionally, von Hippel-Lindau disease is associated with renal cell carcinoma, hypernephroma, cysts in kidney, pancreas and epididymis, and liver. The gene associated with von Hippel-Lindau is a tumor suppressor gene disease localized to the short arm of chromosome 3, thus explaining the occurrence of tumors in this condition.

Cardiac involvement is seen in several neurological diseases. In Friedreich's ataxia, neurologic features start early in life (before age of 25 years) and are characterized by cerebellar signs, loss of posterior column sensations, absent deep tendon reflexes, but extensor plantar response. Cardiac involvement consists of cardiomegaly, hypertrophic cardiomyopathy, and conduction defects. Diabetes associated with insulin resistance and vitamin E deficiency due to low VLDL are interesting aspects of Friedreich's ataxia. Presence of dilated LV with systolic dysfunction, myocardial ischemia, and presence of

Table 4. Non-Atherosclerotic Causes of Coronary Heart Disease

Congenitol obnormolities of caronaries, fistulo, ond myocordiol bridges
Embolism (naturol & iotrogenic)
Dissection (coronory/oortic)
Sposm
Arteritis (Tokoyosu, polyorteritis, SLE, Kowosoki diseose, giont cell orteritis)
Intimol proliferotion (post-transplant)
De novo thrombosis
Substonce obuse (cocoine)
Myocardiol O_2 supply/demond disproportion (ie, oortic stenosis)
Microvosculor ongino (syndrome X)

Table 5. Diagnostic Tests in Pheochromocytoma

Urinory VMA, metonephrines
Urinory free cotecholamines
Plosma cotecholomines
Clonidine suppression test
Provacotive test with glucagon
Locolizotion
CT
MRI
Abdominol aortography
Venaus sompling ot vorious levels in SVC & IVC
Rodionuclide scanning with MIBG

Table 6. Cardiac Involvement in Malignant Disease

Pericordiol effusion
Ventriculor dysfunction secondory to doxorubicin
Amyloidosis
Non-bocteriol thrombotic endocorditis
Metastotic disease to heort
Myocordiol
Introcovitory extension in hypernephromo

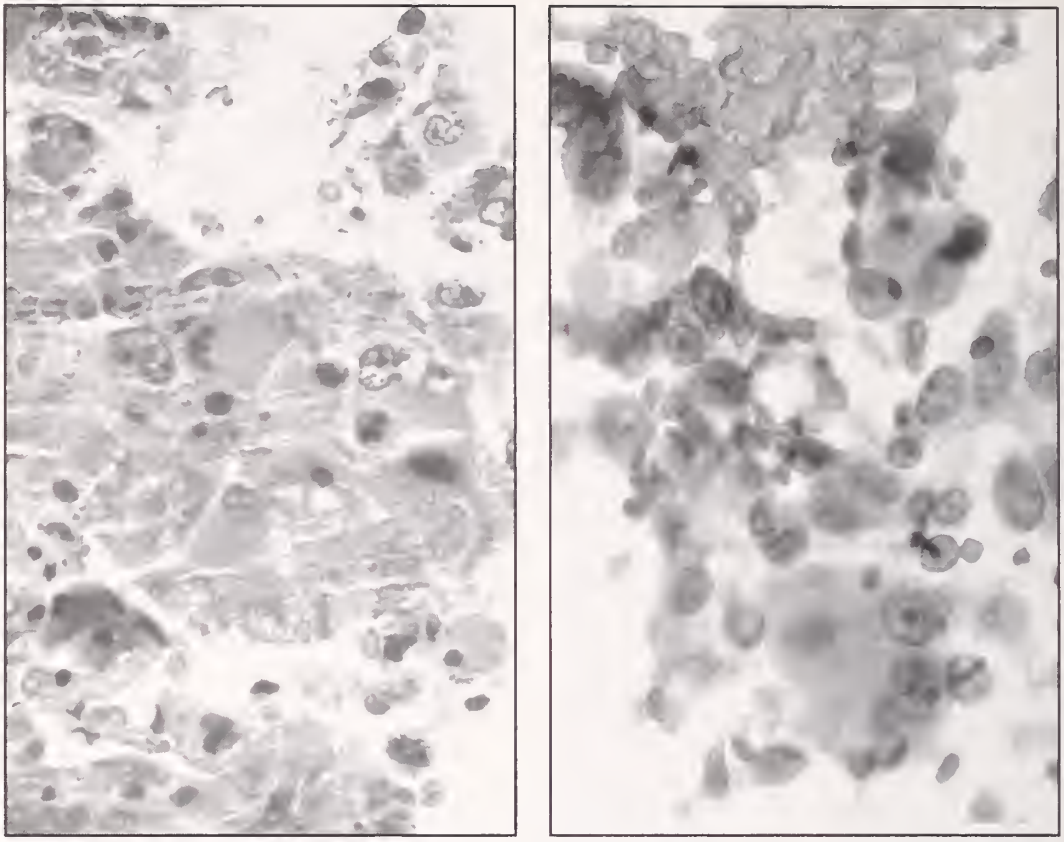


Figure 6. Cytological preparation of the fine needle aspiration (FNA) specimen, showing enlarged cells with hyperchromic nuclei (a). Enlarged pleomorphic nuclei and prominent nucleoli are also seen (b). (a: ×400, b: ×400)

adrenal masses are findings difficult to explain on the basis of Friedreich's ataxia in this patient.

Adrenal masses detected by CT could be adrenal adenoma, adrenal carcinoma, and metastatic disease in the adrenal or pheochromocytoma.[5,6] A significant number of adrenal masses are adenomas. The differentiation between pheochromocytoma and other tumors is made based on biochemical tests (urinary and plasma catecholamines) and not on imaging per se or histology. In this patient with a long history of tobacco use, abnormal chest x-ray, and adrenal mass, it is appropriate to consider adrenal metastatic disease. We do not have evidence of metastatic disease elsewhere; nor do we have evidence of glucocorticoid excess from clinical history. Other adrenal lesions such as tuberculosis, sarcoidosis, and fungal diseases which produce masses cause adrenal hypofunction, and evidence available in this patient does not support that consideration. Of course, if this lesion is metastatic or primary malignancy, the cardiac findings will have to be unrelated to the malignancy. I consider malignancy (primary or metastatic) in this discussion due to the high prevalence of cancers in our patients and also because it appears that tissue diagnosis was somehow made. Cardiac failure is usually not a feature in malignant disease in absence of chemotherapy with doxorubicin. A list of cardiac findings in malignant disease is given in Table 6.

Proteinuria was present in this patient. While we do not have an estimation of the degree of proteinuria or information regarding sediments, the possibility of glomerular disease related to malignancy is worth consideration. Solid tumors from lung, GI tract, breast, kidney, and ovary can produce nephrotic syndrome, mostly as a result of membranous glomerulopathy. While lymphoproliferative malignancies (Hodgkin and non-Hodgkin's lymphoma) also lead to nephrotic syndrome, there is no data suggesting clues towards a lymphoproliferative disease. We do not know if the abnormalities on the chest x-ray on the right side improved with

antibiotic therapy. If he had a primary tumor outside the adrenals, I tend to favor lung as the potential site. Subacute cortical cerebellar degeneration has been described in association with ovarian tumors, breast tumors, small cell lung cancers, and Hodgkin disease—a process mediated through anti-Purkinje cell antibodies. The course of this process is subacute and the long history of cerebellar syndrome in this patient excludes this possibility.

One of the laboratory features seen was elevated lactic acid. We do not know whether this was sustained during the hospital stay or not. However, raised lactic acid in presence of systolic dysfunction and cardiomyopathy raises an interesting diagnostic possibility of a mitochondrial disease. In mitochondrial DNA diseases, oxidative phosphorylation is disrupted, ATP production is impaired, and multiple organs are involved.[7] Neurological features of this condition have been well-described, even though multiple organs can show manifestations. Cardiac findings in mitochondrial DNA diseases include cardiomyopathy and heart failure. Mitochondrial DNA diseases are X-linked. One well-described syndrome is MELAS (mitochondrial encephalopathy, lactic acidosis, and stroke-like episodes).

In summary, I would like to consider two possibilities: 1. pheochromocytoma with cardiomyopathy associated with high catecholamine levels; this may also be a part of a syndrome such as von Hippel-Lindau disease; 2. non-atherosclerotic ischemic heart disease with adrenal mass secondary to metastatic disease, possibly from the lung. The diagnostic test undergone by the patient would be aortography, biopsy, or possibly needle aspiration. Since the pathologist is present here, I believe the latter took place.



Figure 7. A well-circumscribed, light tan-pink tumor. A thin yellow-tan adrenal tissue is also seen.

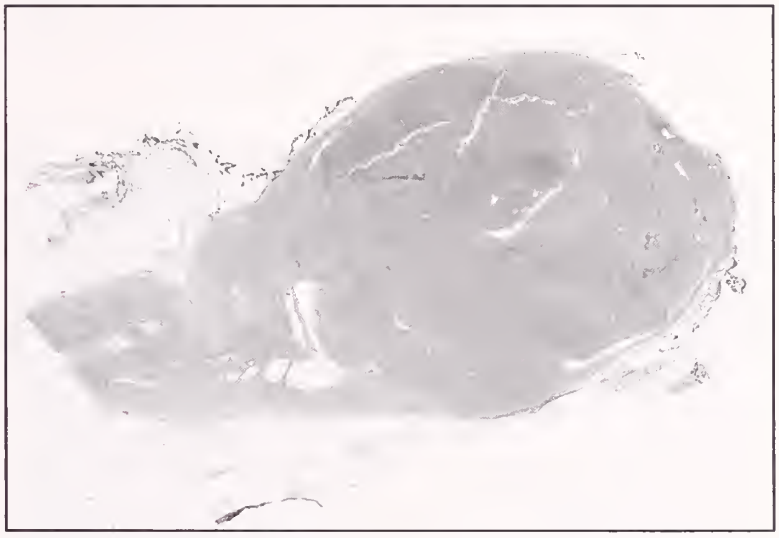


Figure 8. The tumor arising in the adrenal medulla with a thin fibrous pseudocapsule (H&E ×1).

Pathology
Masatoshi Kida, MD

Prior to the surgical resection of the adrenal mass, fine needle aspirate was performed. A cellular specimen was obtained, and some of the cells were rather large and showed enlarged nuclei. Some bizarre large cells with pleomorphic nuclei and large hyperchromic nuclei with prominent nucleoli were also seen (Figure 6).

The resection specimen measured 8.0 × 6.0 × 2.5 cm, showing adrenal gland and periadrenal fat. Eccentrically located within the specimen was a well-circumscribed, light tan-pink tumor nodule, which was ovoid and measured 3.4 × 2.4 × 2.3 cm with approximated weight of 20 grams. It appeared to be arising from the adrenal medulla (Figure 7). Grossly, a smooth outer contour and a thin fibrous pseudocapsule were evident. The fibrous pseudocapsule was very well demonstrated on low power examination of the specimen (Figure 8). There were small areas of hemorrhage and tissue degeneration associated with previous biopsy; other than those areas, there was no area of tumor necrosis or hemorrhage. Interestingly, when the tumor was exposed to a dichromate solution it changed color to dark brown (Figure 9).

Microscopically, the tumor showed nests of tumor cells, which were rather large cells with

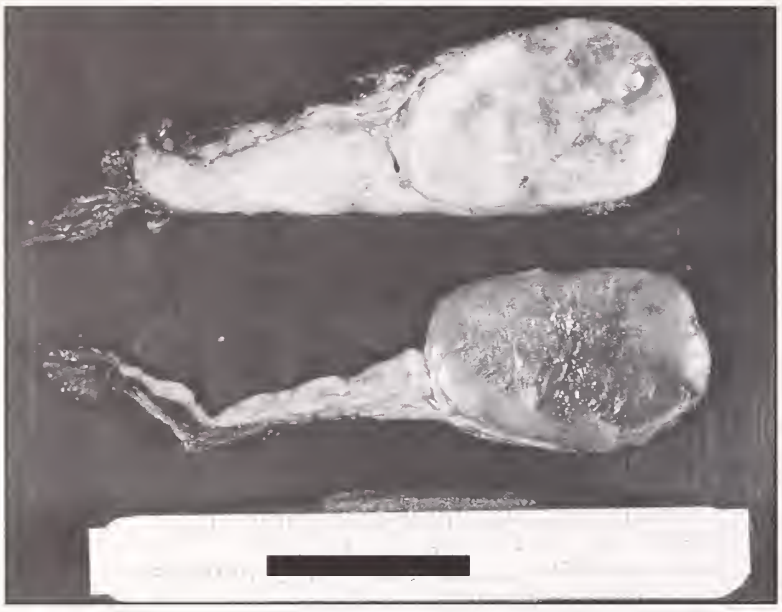


Figure 9. The color change of the tumor, from light tan-pink (top) to dark brown (bottom), with an exposure to a dichromate solution.

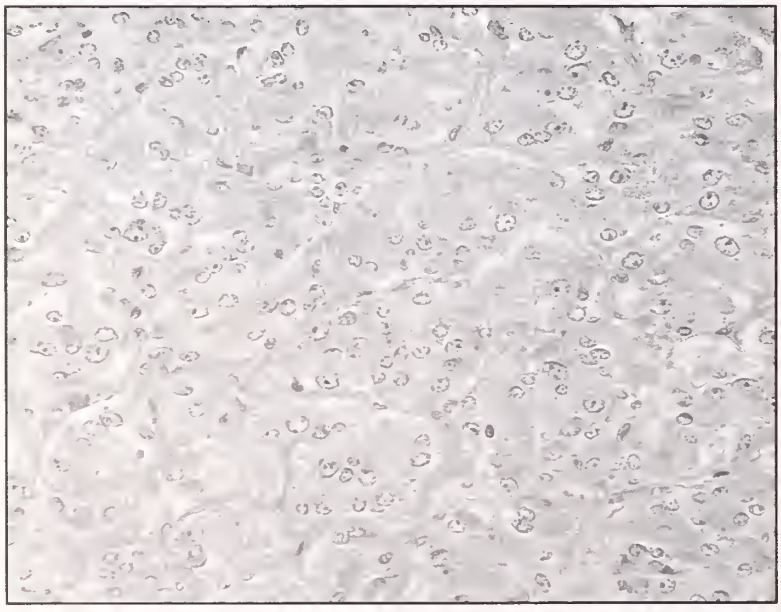


Figure 10. Characteristic "Zellballen" pattern of tumor cell aggregates, which are surrounded by capillaries and a thin network of connective tissue (H&E ×200).

abundant cytoplasm, with prominent nucleoli, and each of the tumor nests was surrounded by delicate fibrovascular connective tissue. On low to medium power examination, these nests of cells appeared as balls of cells (Figure 10), as said in German "Zellballen," the feature very suggestive of a neuroendocrine type of neoplasm.

The examination under a high-power magnification revealed a granular nature of the cytoplasm which was basophilic to amphophilic. The nucleoli were prominent (Figure 11).

Areas showing enlarged bizarre cells with nuclear gigantism and hyperchromism were also noted (Figure 12). DNA ploidy analysis was performed utilizing a Feulgen stain and was measured by the CAS-200 machine (Becton Dickinson Cellular Imaging Systems, Elmhurst, IL). The diploid and near-diploid cells represented 53% of the tumor cells; tetraploid and hyperploid cells represented 22% and 25% respectively (Table 7). The diagnosis of pheochromocytoma was given.

Generally, pheochromocytoma is said to be the "10% tumor": 10% bilateral, 10% extra-adrenal, 10% occur in pediatric population, and 10% are malignant.[8,9] However, some authors argue that 10% malignancy rate is too low.

For sporadic cases, the tumors are usually unilateral and unilocal. However, sometimes pheochromocytoma is associated with other lesions, such as: neurofibromatosis;[10] renal artery stenosis;[11,12] and paraganglioma of the other sites[13] (pheochromocytoma of adrenal is basically a paraganglioma of adrenal medulla); adrenal cortical tumors;[14] and, as Dr. Sivaram mentioned, von Hippel-Lindau disease.[3,4] Also, familial cases of pheochromocytoma have been reported,[15] and in most of the familial cases, the tumors usually show up in pediatric population, and they tend to be multilocal and bilateral. The association with multiple endocrine neoplasm (MEN type II and III, or type IIa or IIb, depending on the classification) has been reported.[16,17]

Morphologically, pheochromocytoma weighs variably from a few grams to 2 kilograms and is well encapsulated with a fibrous pseudocapsule. The tumor is light tan/yellow to red/brown, and if the tumor is large, areas of necrosis, hemorrhage, and cystic formation are also seen. Characteristically, when exposed to a dichromate solution, it changes color from light tan to dark brown ("chromaffin reaction").

Histologically, the "cell balls" are nests of tumor cells surrounded by delicate fibrovascular connective tissue, a characteristic feature of paragangliomatous neoplasm. The cytoplasm is basophilic to amphophilic and finely granular. Prominent nucleoli, and nuclear gigantism and hyperchromicity are not infrequently seen, and the presence of these features is not suggestive of malignancy, nor an invasion through capsular structure. Some cells show intracyto-

plasmic hyaline granules or globules. Immunohistochemically, a series of substances has been shown to be present in the tumor cells (Table 8). Interestingly, most of the extra-adrenal pheochromocytoma shows no epinephrine and the only adrenal pheochromocytoma is positive for epinephrine because the conversion of norepinephrine to epinephrine needs adrenal cortex. Many other substances, including catecholamine synthetases,[18] neuron-specific enolase,[19] chromogranin,[18,20] synaptophysin,[21] and serotonin[22] have been reported. One important aspect of this tumor is that we cannot predict malignant potential simply by its morphological appearance.

This is a tumor on which we need very close communication between pathologist and clinician for diagnosis and patient care. Evidence of distant metastases so far has been the only reliable marker for malignancy. If you compare malignant cases with benign counterparts, malignant tumor tends to be larger and there are more areas of necrosis. Malignant tumors tend to have smaller cells, because they tend to have more cells per unit volume than its benign counterpart. Various modalities have been tried to determine malignancy in pheochromocytoma. DNA ploidy study is one of them, and is in debate to see if it is really useful. In 1996 Pattarino and Bouloux reviewed eight previously published studies about pheochromocytoma to see if any particular features in DNA analysis suggest malignancy.[23] According to their review, the authors stated that tetraploidy carries only 21% of sensitivity to predict malignant potential. Interestingly, even having diploid cannot guarantee benignity.

In the combined 467 cases they reviewed, a significant number of benign tumors are diploid, but aneuploidy and tetraploidy are found in more than 50% of the benign lesions. If you look at the malignant tumor, the percentage of aneuploidy and tetraploidy increases to 95%. However, 3 of 55 malignant cases are found diploid, and simply having diploid doesn't guarantee benignity.

Recently, telomerase activity has gained attention from researchers as a potentially useful marker for malignancy. Telomeres are short, randomly repeated DNA sequences, parts of which are lost during S-phase of cell cycle when DNA is incompletely replicated. Telomerase is an enzyme which recognizes a single-stranded telomere primer, and adds telomeric repeats to its 3′ end to counteract the loss of telomeric fragments.

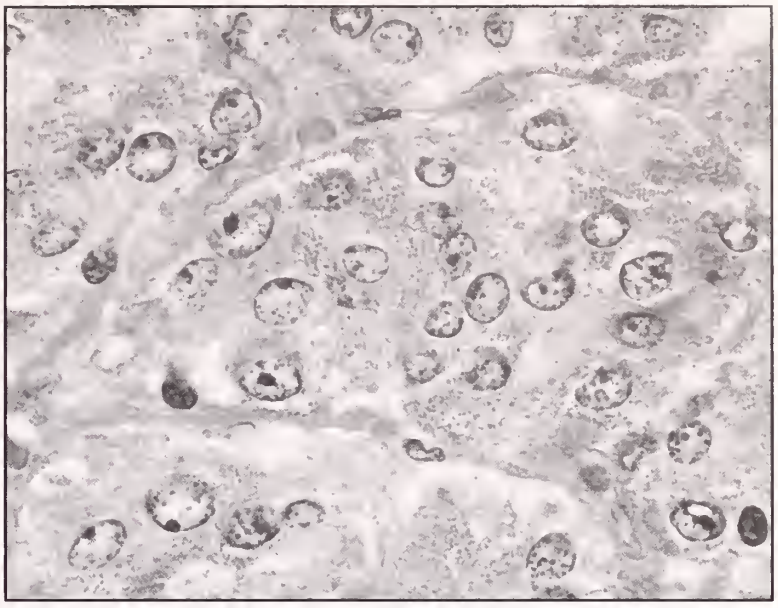


Figure 11. The tumor cells showing basophilic to amphophilic granular cytoplasm and nuclei with prominent nucleoli (H&E ×600).

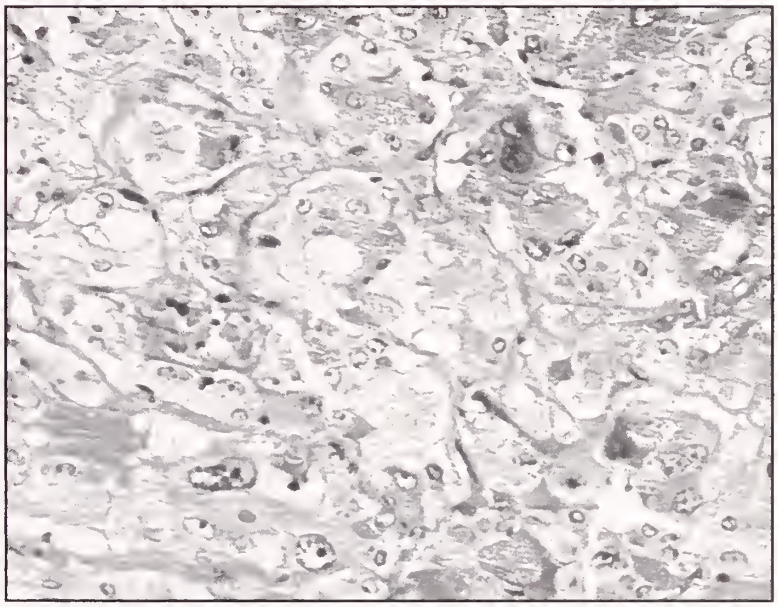


Figure 12. Bizarre tumor cells showing nuclear gigantism and hyperchromism (H&E ×400).

During last year, there were at least two studies, both were from Japan, stating that increased telomerase activity may suggest malignant behavior.[24,25] Kubota and her colleagues studied 16 normal adrenal medullae, 16 benign pheochromocytomas, and three malignant pheochromocytomas and found all three malig-

Table 7. DNA Ploidy Analysis by Feulgen Stain

Cells camprising the GOG (2C) diplaid peak: 11% (DI=0.99)
Cells camprising the aneuplaid (real diploid) peak: 42% (DI=1.21)
Cells camprising the aneuplaid (tetraplaid) peak: 22% (DI=2.04)
Hyperplaid cells with greater than 5CDNA: 25%

Table 8. Substances Seen in Pheochromocytoma

Catechalamines
Catechalamine-synthesizing enzymes
Neuran-specific enalase
Chramagranin
Synaptaphysin
Opaid peptides
Neura-filaments
Seratanin
Samatastatin
Calcitanin
Gastrin
Substance P
Neurapeptide Y
Galanin
Chalecystakinin
Calbindin
Renin
Vasaactive intestinal peptide (VIP)
Carticotropin
Grawth hormane-releasing factars
Peptide histidinemethianine
Cytokeratin
Vimentin
ACTH
Secretagranin

nant tumors showed significantly elevated telomerase activity compared to the normal benign counterpart or normal adrenal medulla.[24]

To measure telomerase activity, radioisotopic telomeric repeat amplification protocol (TRAP) assay has been conventionally used.[26,27] TRAP assay has been further modified to provide quantitative telomerase activity levels.[28] Currently at least two detection kits using enzyme-linked immunosorbent assay (ELISA) are commercially available (Roche Diagnostics, Indianapolis, IN; Oncor, Gaitherburg, MD). An ample amount of information has been accumulated about telomerase. Vasef and others reviewed recent developments regarding telomerase activity and human neoplasms.[29]

Any questions for Dr. Kida or any of our discussants?

Question: If telomerase test is done and the activity level is high, how would you comment about management of the patient?
Dr. Kida: The increased telomerase activity strongly suggests malignant potential, so the patient has to be evaluated thoroughly and followed very closely. That means checking blood catecholamine level and looking for any metastasis—radiographically or by other means.

Question: Did this patient have a biochemical evaluation for pheo prior to his aspiration biopsy, and was he covered with alpha blockers prior to this aspiration biopsy?
Dr. Bahu: He actually did not get studied before his biopsy. He was preadmitted; the diagnostic study was for the biopsy.

Question: Was he covered?
Dr. Bahu: No, he got biopsied, and then had a reaction; after that, we did the studies, and they all came back confirmatory. Before surgery he was covered, but not before the biopsy.

Comment: I would like to make the point that that was serious error in the medical handling of this kind of patient. A patient with a potential pheo should never undergo a needle aspiration without coverage for alpha blockade. And that is a potentially lethal error.

Dr. Walter: I would like to make one remark here. This is a rare lesion to see with contrast on CT. Generally, if a pheo is suspected, the radiologist is advised and we get a non-contrast examination, and we never get to see it enhanced. He did not react to the contrast materials, but he did react to the biopsy.

Question: Did the patient have hypertension? There are only a couple of blood pressures through his chart and no evidence of hypertension at all.
Answer: There was no hypertension.

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COMMENTARY

Drug Seeking Behavior—A Differential Approach

William H. Yarbaraugh, MD

"Drug seeker" is a common term for patients wha are perceived ta be seeking drugs that might be abused ar used in an illegal fashion. While there are patients who seek drugs for totally illegitimate reasons, most of these patients have some type of underlying medical issue. A differential model is prapased using four categories of seeker. The first is fraudulent behavior, second is addictive disease, third is under-treated symptomatalagy such as pain, and last is psychiatric disorders.

Each area is discussed with useful examples af behavior in each category. With a good warking knowledge of these areas described, physicians can more effectively manage this difficult group af patients.

Introduction

"Drug seeker" is a common term that physicians and other health care professionals often use to label difficult patients. Most of us see these types of patients on a daily basis. You know the type—consider the chronic back pain patient, the headache patient, and above all, the dreaded fibromyalgia patient. Consider here as well the patient who comes in asking for a controlled substance by name, such as the patient that knows which benzodiazepine is effective for their nerves, or which narcotic in the past has relieved their pain.

We have been conditioned throughout training and practice to joust with these patients relentlessly, often eventually discharging them from our practice with a smug, "I do not put up with this kind of behavior in my practice." "They" ruin our day.

Trying to understand the issues involved here, I attended several seminars on detecting the drug seekers; not once did I find a physician involved in the program except to introduce the speaker. The instructors were usually some type of law enforcement officer with well-meaning tips on catching con artists. They seemed to assume that all patients, except with the possible exception of terminal patients, had criminal intent in seeking drugs. One speaker even talked about watching out for the terminal patients because he had heard of them selling their narcotics. I have not heard any of the officers discuss the differential diagnosis of this behavior or present an evidence-based paper on drug seeking.

None of the speakers seemed to possess any knowledge regarding the legitimate use of controlled drugs. But I found myself in a room full of physicians being lectured to about the inherit evils of drugs. In my experience, most of these patients had been seeking help for a medical illness and most were not criminals. They present us with difficult issues for which we have not been prepared. so we throw them in a "box" labeled drug seeker. At that point it becomes excusable to essentially ignore them or get rid of them. We may not consider them criminal, but often view them as undesirable.

Thinking about patients I have seen who were labeled as drug seekers, it became apparent that most of these patients had legitimate underlying medical problems. In many cases, the prevailing system puts them in a situation that requires them to manipulate the system to obtain what they perceive they need. Being an internist, I have found it useful to think of drug seeking as a symptom of an underlying problem, not a diagnosis. Four broad categories come to mind. As with many medical issues, patients may fall into more than one category.

Criminal or Fraudulent Behavior

The first category is criminal or fraudulent behavior. Unfortunately, there are individuals that

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visit a physician's office with purely invented symptoms to obtain drugs for illegal diversion. These individuals usually appear healthy, have no documentable medical history, and are rarely willing to negotiate an acceptable treatment plan. These people are looking for as many prescriptions as they can obtain until the physician catches on. Of course, when this activity is apparent, physicians should decline to prescribe. On the other hand, a physician acting in good faith with appropriate medical evaluation should not be held responsible for the willful deceit and fraudulent intent of these individuals. Although this is what we worry about most, I suspect that pure fraud without other underlying issues account for a small percentage of patients labeled drug seeker, although clear data is unavailable.[1]

Addiction

Secondly, the disease of addiction is a major reason for drug seeking. Many of the patients addicted to prescription medication started out with a legitimate medical or surgical problem.[2] They did not know they suffered from an underlying disease of addiction, and many are never told. Other addicts may seek drugs to supplement the street drugs they use. In essence, addiction is a treatable medical disease.[3]

Because of the often-illegal acts persons suffering from addiction use to feed their addiction, the disease of addiction has been essentially criminalized. Prescribing controlled substances on a chronic basis requires a good working knowledge of addiction. Unfortunately, many physicians have no better than a layperson's view of addiction. The hallmark of addiction is loss of control over the usage of the substance in question, along with impulsiveness and continued use despite consequences.[3] The standard Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)[4] criteria for diagnosis of psychoactive substance use disorder cannot be used reliably to diagnose addiction in the presence of opioids prescribed for the treatment of pain. Many of the DSM-IV criteria defining addiction refer either to physical dependency or tolerance, both of which are physiological and expected with long-term opioid use, or to other occurrences that may be normal and expected in the course of opioid therapy of chronic pain.[5] Only those criteria that reflect addictive behavior should be considered in this setting of chronic pain.

The patient who has been taking hydrocodone three to four times daily for severe arthritis for three years on a scheduled basis is not an addict. The patient who has been on long-acting morphine for two years for chronic back pain who functions well on the medication, has a good quality of life, and sticks to the regimen is not an addict. The patient who constantly gets refills early, can never adhere to the program, tells lots of strange stories about lost meds and prescriptions, and sees multiple doctors for medication very possibly has the disease of addiction.

Addiction is probably the most under-treated treatable disease in this country. Multiple studies have documented the success of well-monitored treatment programs.[6-10] The cost effectiveness and years of life saved have been well-documented in several large studies. In fact, one study indicated that in years of life saved, addiction treatment was comparable to immunizations and prenatal health care. Some studies have suggested that well-done addiction treatment is as successful in meeting goals as are our treatments for hypertension, diabetes, and asthma.[12-14] All these chronic diseases require active participation of the patient to be successful. Well-motivated patients do very well in addiction treatment.

Physicians need to be willing to make the diagnosis when apparent, and know how and where to make appropriate referrals. If the patient refuses, then the prescribing of controlled substances should cease. I again emphasize that appropriate knowledge of addiction is a must for almost all types of medical practice. Dependence on a controlled drug to maintain function, with controlled and stable usage, is not addiction. If uncertainty exists, referral to an addictionist or other knowledgeable physician would be appropriate. Remember, addicts do not take three or four pain pills a day—they usually take 30 or 40.

Under-Treatment or Inappropriately Treated Pain

Thirdly, patients may exhibit drug-seeking behavior because of under-treated or inappropriately treated pain. Chronic pain can be one of the most difficult problems we treat. It certainly is not criminal to seek relief from relentless pain. Pseudoaddicition is a phenomenon first observed in cancer patients being treated for pain. Under-treatment of serious pain may lead to behaviors much like that seen in addiction.[15] Examples such as early refill requests, multiple physicians, hoarding, or even alterations of prescriptions are seen.

Individuals who have severe, unrelieved pain may become intensely focused on finding relief for their pain. They may appear to be preoccupied with obtaining opioids, but the real preoccupation is with finding some relief. When appropriate pain management is provided the previous behavior resolves.[5] When possible, efforts should be made to relieve chronic intractable pain. In many patients, chronic nar-

cotic therapy may be the only available modality that is effective. Uninsured patients often lack access to most alternative therapy, leading to earlier use of narcotics. The majority of patients can be treated successfully with chronic narcotic therapy.

Patients who develop addiction in the course of treatment should be referred appropriately. Signs of developing addiction in the pain management setting include apparent intoxication in the office or reports from family, deteriorating functional levels, and increased complaints of anxiety or insomnia. Assistance from both a pain management specialist and addictionist may be helpful.

Addiction in most large studies develops in less than 15% of patients treated with chronic narcotics.[16-19] With effort, knowledge, and a team approach, most patients can be successfully managed. Ignoring the suffering of these patients is as inappropriate as over-prescribing medication and should be treated as such by medical boards and other agencies.

Underlying Psychiatric Disorders

The fourth category involves patients with underlying psychiatric disorders. This includes patients with severe anxiety disorders and panic disorder.[20] The disorders can be devastating and patients will often request medications they have used before that were effective. I have seen patients who have been on a relatively small and stable dose of a benzodiazepine for many years, who then see a physician who refuses to prescribe (or recommends discontinuation of) the drug without considering the reason the patient is on the medication. This does not mean the patient wants to misuse, abuse, or divert the drug.

There are other non-abuseable drugs available to treat these disorders, but once a patient is labeled a drug seeker, often efforts to effectively treat the patient cease. In some cases benzodiazepines may be the only effective medication. Individuals with bipolar disorder may seek drugs to self-medicate.[21] Patients with certain personality disorders may abuse drugs, as well as those with Posttraumatic Stress Disorder (PTSD). If any signs of these disorders are apparent, referral to a psychiatrist is in order.

Conclusion

Using the differential model, it is clear to me that most patients exhibiting drug-seeking behavior can be managed if a physician has appropriate knowledge about addiction, chronic pain, and a few psychiatric disorders. Some physicians may be uncomfortable with this, but certainly recognizing and referring appropriately is a minimal requirement for primary care physicians.

When managed effectively, often these patients suddenly become not so difficult. In fact, a significant part of the problem has more to do with the physician's own bias and fear as it does with any particular medical issue. I believe it is the physician's duty, when possible, to try to alleviate suffering—whether it is from addiction or true chronic intractable pain. Maybe if we listened more, focused on the patient more (instead of the drug at issue), and used professional caring instead of judgmentalism, then these patients will be more manageable and our lives less frustrating. JJ

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Effects of Smoking on Health Care Costs

Ambika K. Nair, MBBS; Edward N. Brandt, Jr., MD, PhD

Smoking is the leading preventable cause of death in the United States. The US Centers for Disease Control and Prevention (CDC) estimate that smoking kills approximately 419,000 people in the United States each year. Cigarette smoking is the nation's leading cause of premature mortality, and is responsible for one-third of all deaths among working-age Americans. Smoking cigarettes is both psychologically and physiologically addictive. Smoking is an important risk factor for cardiovascular diseases, especially coronary artery disease, stroke, carcinoma of the lung, chronic bronchitis, chronic obstructive pulmonary disease, and emphysema. It also increases the risk for peripheral vascular disease and is associated with cancers of the larynx, oral cavity, esophagus, pancreas, and urinary bladder. Smoking by pregnant women can cause adverse health effects on their babies, like low birth weight and preterm delivery; increases the risk of miscarriage; and has also been found to be an important cause of sudden infant death syndrome. Careless smoking also can cause severe burn injuries and death. Many of these adverse effects of smoking occur in "second-hand" smokers.

Literature Review

Smoking prevalence rates have remained consistently higher for men than women and for blacks compared to whites.[1] These gender- and race-specific differences in smoking prevalence are reflected in differences in attributable mortality rate and years of potential life lost. In 1993, the direct medical care costs attributable to smoking in the United States were estimated at $50 billion: $26.9 billion was associated with hospital expenditures, $15.5 billion with physician-related expenditures, $4.9 billion for nursing home expenditures, $1.8 billion for prescription drugs, and $900 million for home health care.[1] The average per capita health care costs for all smokers in 1985 has been estimated at $205, ranging from $54 per capita in Puerto Rico to $284 per capita in Rhode Island. The average lifetime costs for males are 32% higher for smokers than for never smokers ($35,914 versus $27,276); among females, the average costs are 24% higher for smokers than for never smokers ($52,902 versus $42,783). Compared to never smokers, total lifetime medical expenditures are 47% higher for male heavy smokers (25 cigarettes a day or more) and 41% higher for female heavy smokers.

Direct health care costs include the costs for prevention and treatment of smoking-related diseases. In a study of the health and economic implications of a work site smoking cessation program by Kenneth Warner and his colleagues,[2] their program cost was assumed to be $150 per participant. Smoking cessation intervention ranges from less than $5 for a "how to quit" booklet to several hundred dollars for physician-directed counseling and follow-up with nicotine replacement. This cost includes program planning, recruiting participants, securing space, etc. They found smoking cessation to be a very sound economic investment for the firm and is particularly profitable when long-term benefits are included with an eventual benefit-cost ratio of 8.75. Saving life years at a cost of $894 each, the program is more cost effective than most of the conventional medical care covered by the firm's insurance.

Total health care costs associated with smoking includes the cost of disease in children due to parental smoking, non-fatal smoking-related injuries, cataracts in smokers, and the often

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Table 1. Average and Incremental Costs of Maternal Conditions Affected by Smoking During Pregnancy[8]

Maternal conditions	Average costs	Incremental costs
Ectopic pregnancy	$8,382	Not applicable
Placenta previa	$10,069	$5,551
Abruptia placenta	$7,606	$3,088
Preterm premature rupture of the membrane	$9,422	$4,904
Pre-eclampsia with delivery	$8,477	$3,959
Spantaneaus abartian	$4,747	Nat applicable

non-fatal secondhand effects of other people smoking on non-smoking adults. Health care costs among adult nonsmokers for asthma exacerbation from secondhand smoke and burn and blast injuries from other's careless smoking exceeded health care cost savings from premature death.[3] Smoking and alcohol consumption habits are strongly associated with socioeconomic variables such as education and employment (higher smoking rates are found in less educated groups and in those receiving unemployment or other benefits).[4]

In Alaska, direct medical care costs in 1993 due to smoking-related illnesses were estimated at $96.49 million.[5] Additional smoking-related costs include indirect mortality costs of $183.2 million and indirect morbidity costs of $15.9 million. From 1992 to 1994, smoking was estimated to result in 470 deaths per year and economic costs of almost $300 million per year.[5] In Alaska, they used SAMMEC (Smoking Attributable Mortality, Morbidity, and Economic Costs) software developed by CDC to estimate deaths and the economic impact of smoking. The majority of Alaska smokers began smoking between 10 and 20 years of age. In the United States as a whole, almost no regular smoking begins after the age of 18.

A debate goes on with respect to health care cost and smoking. Smokers have more disease than nonsmokers, but due to non-smokers living longer, they can incur more health costs at an advanced age. The authors do not feel this fact is meaningful since it is against our medical ethics. Just because nonsmokers live longer and incur more health care costs due to longevity, we cannot encourage smoking nor do nothing for smoking cessation.

Barendregt and colleagues[6] found that health care costs for smokers at any given age are as much as 40% higher than those for non-smokers; but in a population in which no one smoked, the cost would be 7% higher among women than the costs in the mixed population of smokers and non-smokers.[6] They found that the per-capita health care costs rise sharply with age, increasing almost ten times from persons 40 to 44 years of age to those 85 to 89 years of age. In each age group, smokers incur higher costs than nonsmokers do. The difference varies with the age group, but among 65 to 74 year olds, the costs for smokers are as much as 25% higher among women. All smoking-related diseases are associated with higher costs in a population of smokers than in a population of nonsmokers. This relationship is particularly strong for the diseases with the highest risk, like lung cancer and chronic obstructive pulmonary disease. The data indicate that if all smokers quit, health care costs would be lower at first, but after 15 years they would become higher than at present. They conclude that if people stopped smoking, there will be a saving in health care costs, but only in the short term; eventually, smoking cessation would lead to an increase in health care costs due to aging costs.

The tobacco industry annually spends billions of dollars to promote tobacco use and to influence public opinion. They also lobby legislators and public officials extensively to block anti-smoking bills or to support their desirable bills. Public opinion plays a major role in passing or not passing bills. Seth Emont and colleagues[7] in their study revealed that there was strong public support for public policy and legislative efforts to restrict smoking in public places for health and safety reasons. The public is becoming more aware of the dangers of secondhand smoking.

An estimated 26% of women of reproductive age smoked in 1993.[8] The adverse health effects of smoking during pregnancy on the fetus and neonate are also well documented. Tobacco use is related to intrauterine growth retardation (small for gestational age), low birth weight, perinatal mortality, and sudden infant death syndrome. Yet 19% of American women reported continuing smoking even when pregnant. Other studies suggest that as many as 27% of American women smoke during pregnancy. Numerous studies in the epidemiological and clinical literature have shown that smoking is related to the following maternal conditions: ectopic pregnancy, placental complications, premature rupture of membrane, and spontaneous abortion. These conditions either prevent the pregnancy from reaching full term, or make the delivery more complicated and more costly. Smoking also increases the risk of pelvic inflammatory disease. All of these increase health care costs. The average and incremental

Table 2. Parameters Used in Simulations for Events Prevented by Smoking Cessation[9]

Event	Myocordiol inforction (meon)		Stroke
Sex	Male	Femole	Bath
Prapartian of smakers	0.301	0.250	0.275
Prapartian af ex-smakers	0.288	0.205	0.245
Observed incidence in the papulatian	0 .00052	0.00159	0.00219
35- ta 64-year ald cahart size, n	46,409,600	48,410,200	94,820,000
No. of smakers equivalent	46,009,600	484,102	948,200
1% draps in prevalence			
Annual survival prabability	0.99163	0.99497	0.99334
Annual survival probability after event			
First year	0.812	0.765	0.663
Secand ond follawing years	0.944	0.933	0.961
Average cost af event, 1995 US dallars			
First year	30,924	30,819	29,043
Secand year	1,922	1,817	6,887
Third year	1,268	1,163	1,618
Faurth year			1,481
Fifth year			1,190
Sixth year			593

cost of each maternal condition affected by smoking during pregnancy, based on private sector health insurance claims in 1993, is given in Table 1.

Lightwood and colleagues[9] estimated the time course of the fall in risk of acute myocardial infarction and stroke after smoking cessation, and simulate the impact of a 1% absolute reduction in smoking prevalence on the number of, and short-term direct medical costs associated with, the prevented acute myocardial infarctions (AMIs) and strokes (Table 2). Smoking kills over 400,000 smokers and 50,000 nonsmokers annually. Investments in reducing smoking prevalence often are not viewed as productive because of the length of time it takes to reduce treatment costs by preventing cancers and chronic lung disease. The excess risk of a myocardial infarction or stroke falls by approximately 50% within the first 2 years after stopping smoking. Treatment of these conditions is expensive, and their prevention provides immediate short-term financial returns for both private and public health insurers.

Total medical costs for acute myocardial infarction (AMI) have three parts.[9] The first part is the average costs associated with initial treatment for an AMI. The second part is the expected cost of major surgical procedures, such as angioplasty and coronary artery bypass surgery. About half the cost of an admission for AMI arises from revascularization procedures. The third part of the cost consists of annual direct medical follow-up and rehabilitation costs.

There are three components to the cost of stroke: the direct short-term care cost of treatment, rehabilitation costs, and the costs of care in nursing facilities. The medical costs include hospital room and service charges, physician and other health professionals' fees, and ancillary charges. See Table 3 for a summary of direct and indirect costs of smoking and lung cancer.

Table 3. Classifications of Costs in Economic Evaluations of Smoking and Lung Cancer[10]

- **Direct costs:**
 - Medicol:
 - Haspitol
 - Nursing core
 - Physicians
 - Other health-care practitioners
 - Drugs
 - Medical pracedures
 - Nan-medical:
 - Transpartatian costs
 - Out-of-pocket expenses relating ta health care
 - Fires
 - Damage fram cigorette burns and smake
 - Attempts ta quit smaking
 - Casts af hiring and training replacements far ill smakers
- **Indirect costs:**
 - Tangible Costs:
 - Last praductivity
 - Faregane manpower resources
 - Time last by family members caring far ill individuals
 - Intangible Casts:
 - Psychologicol distress
 - Reduced quality of life

They found that a 1% reduction in the absolute smoking prevalence rate caused 924 fewer hospitalizations for AMIs and 538 fewer strokes. Because approximately 17% of people

suffering AMIs die before reaching the hospital, they estimated an additional 190 deaths would be prevented. After seven years, the annual reduction in the incidence of AMIs and strokes approaches a steady state of approximately 3,200 hospitalizations for AMI and 1,700 for stroke each year. The medical costs avoided are $44 million in the first year, increasing to approximately $168 million per year at steady state. The cumulative savings in the medical costs avoided amount to $933 million over seven years. They also estimated the discounted present value of short-term medical costs associated with AMI and stroke avoided to approximate the cost to a health care organization (such as HMO) of creating an ex-smoker. The average ex-smoker will reduce medical costs by $47 in the first year. Over a seven-year period, the expected reduction in direct medical costs for each ex-smoker is $990 (undiscounted) or $853 and $738 (using 2.5% and 5% discount rates, respectively). Their analysis shows that there are substantial short-term benefits to assisting adult smokers in stopping smoking, and that these benefits accrue rapidly as one extends the time horizon used to assess the benefits of creating a new nonsmoker. In particular, a national program that would reduce smoking prevalence by 1% per year would prevent 98,100 hospitalizations for AMIs and strokes (and 1,300 deaths of acute myocardial infarction outside the hospital) and eliminate the need to spend approximately $3.2 billion (undiscounted) on the treatment of myocardial infarction and strokes over a seven-year period.[9]

These results emphasize the importance of encouraging smoking reduction across a broad range of ages. Although primary prevention is important, much of the cost of smoking—in terms of cardiovascular disease—is not incurred until early middle age. The study by Lightwood et al shows that there are quick and substantial benefits to implementing programs that reduce the number of adult smokers. In addition, it is through interventions that reduce adult smoking that one can demonstrate the kind of short-term changes in cigarette consumption that appears necessary to convince policy makers to make the necessary investments in tobacco use prevention. Bradley et al[9] showed that continuing smokers have a higher incidence of subsequent events than nonsmokers or quitters after an AMI, and that they incur more costs.

Helyer[11] estimated the disease burden of cigarette smoking for the Department of Defense (DoD) health care system in terms of smoking-attributable morbidity, mortality, excess medical care, and excess disability. The DoD health care system, with some 8.3 million people eligible to receive care, is one of the largest in the world. The prevalence of smoking among active-duty personnel in the DoD is approximately 32% (1995). Approximately 54.6% never smoked, 13.8% were non-smokers, and 31.6% smoke.[11] Direct health care costs reflect expenditures for those involved in the prevention, diagnosis, and treatment of the smoking-related diseases and medical conditions like infectious diseases, neoplasms (of lip, oral cavities, pharynx, esophagus, pancreas, larynx, trachea, lung, bronchus, cervix-uteri, urinary bladder, kidney), cardiovascular diseases (coronary heart disease, other heart disease, cerebrovascular disease, other arterial disease), respiratory diseases (chronic obstructive pulmonary disease, other respiratory diseases), burn deaths, and perinatal conditions. In calculating direct health care expenditures, the excess medical care utilization rates for smokers are applied to the costs of treating disease for which smokers are at increased risk. Fifteen percent of DoD active duty military persons are heavy smokers (smoke a pack or more of cigarettes per day). Indirect mortality and morbidity costs are based on an estimate of output lost because of cessation or reduction of productivity caused by smoking-related death or disability. Direct health care costs attributed to smoking were estimated at approximately $584 million.[11]

Hospitalization costs, at 77%, represent the largest portion of direct health care costs. The second-largest category of costs was physicians' fees, representing 18% of direct health care costs. Male smokers bear the largest share of these total direct health care costs, about 74%. Almost 80% of the hospitalization costs for male smokers occur among those aged 35 to 64 years. Among female smokers, about 63% of the total direct health care costs are incurred by those aged 35 to 64 years. Smoking-attributable deaths account for one in six deaths, about 16% of the deaths in the DoD population in 1995.[11] Deaths caused by cardiovascular disease, neoplasms, and respiratory disease accounted for the largest percentage (99%) of smoking-attributable deaths. Cardiovascular deaths accounted for the largest percentage (45%) of smoking-attributable deaths among those aged 35 years and older. Neoplasms, including lung cancer, accounted for the second-largest percentage of deaths (35%). Respiratory diseases accounted for 19% of smoking-attributable deaths. Approximately

10% of all DoD hospital bed days and approximately 1.5% of all active duty hospitalization time were for smoking-attributable diseases. Of the 976 deaths caused by smoking-related illness among the total DoD population, an estimated 649 lives were lost before age 65. One in six deaths were attributable to smoking. The morbidity costs amounted to $187,450,064 for male smokers and $67,183,300 for female smokers. Cardiovascular mortality costs represent the largest share of the indirect mortality costs (almost $78,187,981), neoplasms account for the second-largest share (about $59,960,954). Male smokers bear the largest share of the indirect mortality costs, about 65%. The bed day calculation reveals that only about 4.6% of the smoking-related costs is for active duty personnel.[8]

Prevention is usually emphasized as a way to control the costs of smoking. As an example, consider the study by Secker-Walker et al,[10] who examined the costs and cost effectiveness of an American mass media program in conjunction with a school-based curriculum designed to reduce smoking among children in grades 5 to 10. The total cost of the mass media program was $759,436 and the cost per student potentially exposed was $41. The program cost per smoker averted was $754, and the cost per life-year gained was $696 (discounted at 3% per year).

Lung cancer is a major public health concern, not only because of the resultant morbidity, mortality, and cost, but also because the primary etiologic factor, smoking, is known.[10] This public health concern is amplified by the fact that the increased risk of lung cancer extends to passive smokers also. Lung cancer is estimated to account for approximately 20% of all the cancer care costs in the United States, which represents 2% of all health care costs.[10] In absolute dollars, lung cancer costs the American health care system $8 billion annually, and the Canadian health care system $328 million annually. In the developing world, the health care costs for tobacco-related illness approach $70 million annually.

Discussion

US tobacco companies have agreed to pay $368.5 billion over 25 years in a landmark settlement with the attorneys general from 40 states. Under the agreement, which has yet to be endorsed by President Bill Clinton[12] or Congress, the companies admit that cigarettes are addictive and cause cancer, heart disease, and lung-related illness. They would also pay $4 billion a year into a fund to compensate smokers who were successful in a lawsuit. The agreement gives the Food and Drug Administration authority to reduce the levels of nicotine and eliminate it by the year 2009 if appropriate. The companies would be given time to find a nonaddictive alternative.[12] The industry would have to pay large fines if the smoking rates among young people were not reduced by 30% in five years and by 60% in 10 years. President Clinton said, "we must carefully consider whether approving this proposed settlement will protect the public health, and particularly our children's health." Dr. David Kessler, former commissioner of the Food and Drug Administration, said, "we need to see what the industry got out of this."[12] Britain's largest tobacco group, Gallaher, said that the deal was likely to put pressure on British companies to reach a similar settlement. Health authorities in Britain are considering legal action against tobacco companies to recover the costs of treating patients with smoking-related illness.

Effective smoking prevention and cessation programs can reduce the need for subspecialists (like cardiologists, oncologists, and pulmonologists) in the future. Elimination of smoking by expectant parents can prevent eight perinatal deaths each year, starting immediately. The fact that smoking is a legal activity underscores the importance of the health promotion approach in reducing tobacco use. Because tobacco use is a learned behavior, it is amenable to preventive measures. Vigorous efforts are needed to prevent the initiation of smoking, encourage smoking cessation, and strengthen control measures. Reducing tobacco use would lessen the human and economic burden on the health care system and society.

Smoking can be reduced through an educational program that focuses on smoking, physical activity, and nutrition. All doctors have a duty to campaign against tobacco use. Legislators should raise the tax on tobacco for three reasons:[1] first, increased cost of cigarettes is more likely to discourage nonsmokers from starting to smoke; second, current smokers will more likely reduce their daily consumption; and finally, the smokers will pay their share for the medical costs and lost productivity to the public. Societal interventions also impact on smoking rates, such as the "nonsmokers rights" movement; excise taxes; health warnings placed on cigarette packages; work site smoking cessation programs; raising the age limit for buying cigarettes; making all public places smoke-free; increasing insurance premiums for smokers; extensive edu-

cation programs in schools; role modeling by parents, teachers, and friends; and the restriction of tobacco advertisements. All of these can prevent or stop smoking and thereby reduce the effect of smoking to the health care system. The General Accounting Office estimated the effect on teenage smoking of a tax increase and predicted that a 21% tax increase would result in the number of teenage smokers being reduced by more than one-half million.[13] Smoking cessation would likely be associated with a net economic benefit to the society but also, more importantly, with enhanced quality of life of the population. Such efforts should continue to be energetically pursued at all levels using a variety of approaches that include legislation, litigation, and both population-based and individual-based interventions to reduce consumption among current smokers and discourage the adoption of the habit by new smokers. J

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The Economics and Costs of Smoking

Think smoking is only costly for the smoker? Think again...



How much does smoking cost society?

Smoking costs society about $130 billion per year (this figure includes medical costs; the costs of smoking during pregnancy; the cost of lost workdays; the cost of lost output from early death and retirement; the costs of fires caused by smoking).[1]

How much money do we spend on smoking-attributable illnesses?

In 1993, the health care costs associated with smoking totaled $50 billion: $26.9 billion for hospital costs; $15.5 billion for doctors; $4.9 billion in nursing home costs; $1.8 billion for prescription drugs; and $900 million for home health care expenditures. Adjusting for inflation, tobacco use may result in excess medical expenditures of nearly $60 billion.[2]

How does smoking affect lost output and workdays?

Smokers tend to die younger and retire sooner than nonsmokers do. Over and above the medical costs, this would carry a price to the economy in lost output and lost wages. This cost is estimated at $80 billion a year. In addition, there is a further tangible drain on the economy of around $500 million, due to the fact that smokers miss 50% more workdays than their nonsmoking colleagues.[3]

How many people need to quit smoking before we see an effect on the health and economy of our nation?

A one-time, one percent (1%) reduction in the prevalence of smoking produces substantial short-term savings. In the first year, an estimated 924 heart attacks and 538 strokes are avoided, saving approximately $44 million.[4]

How much money does the tobacco industry make?

The tobacco industry is one of the most profitable businesses in the country: in 1991, tobacco manufacturers' revenue was $32 billion.[5]

How much money does the tobacco industry contribute to political parties?

The tobacco industry contributes over $5 million to federal candidates and political parties. Tobacco industry expenditures in 1998 to influence state ballot questions and for a media campaign against the McCain tobacco control bill equaled over $70 million. The tobacco industry spent more than $40 million lobbying Congress during the first half of 1998.[1]

How much money does the tobacco industry spend on advertising?

In 1994, tobacco companies spent an estimated $5 billion to advertise and promote cigarettes.[6]



How does advertising affect brand preference?

Eighty-six percent (86%) of adolescent smokers who bought their own cigarettes preferred Marlboro, Camel, or Newport—the most heavily advertised brands. In contrast, only thirty-five percent (35%) of adults chose these brands.[7]

How cost-effective is implementing a cessation program for an insurance company?

The full-coverage cost of $328 per user is a bargain compared to the average annual costs for the medical treatment of hypertension ($5,921) and heart disease ($6,941), which are usually continued for the life of the patient.[8]

Patient Handout #6

Does taxing or raising prices on cigarettes really decrease smoking?

As with almost all other products, the demand for cigarettes decreases as price is increased. It has been estimated that an increase of $2 per pack in cigarette taxes will result in 7.6 million fewer smokers.[9]

The price of cigarettes keeps getting higher. Where does all the money go?

$.41—payment to state governments as reimbursement for treatment of smoking-related illnesses.
$.09—legal fees: 4¢ go to the states' lawyers, and 5¢ to Phillip Morris's lawyers.
$.03—cash outlay to tobacco farmers.
$.28—profits for Philip Morris, after taxes.
$1.20—taxes: the federal government takes 43¢ (19¢ in income tax, 24¢ in sin tax). The states vary in taxes.
$.16—cost of cigarette production including tobacco, which amounts to 8¢ per pack.
$.17—advertising and special merchandise.
$.38—givebacks to retailers.
$.57—retailer markup (this varies).
$.21—distribution, including various middleman fees like wholesaling and warehousing.[10]

How much does fire damage from cigarettes cost the United States?

Fires started by smoking cause an estimated $500 million worth of damage every year, and this does not even begin to account for the roughly 2,000 lives that are lost every year in these fires. Additionally, some studies have even estimated large costs for cleaning and repairing homes and offices due to smoking, but these are not included in the total.[11]

How much money does a smoker spend annually on cigarettes?

Currently, cigarettes cost about $2.50 per pack.[12] A pack-a-day smoker can save more than $912 per year, each year, for the rest of his/her life, by quitting.

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, Information Dissemination Program.

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Patient Handout #6

Paddack Takes Office as National President



Susan Paddack of Ada will be installed as AMA Alliance President on June 13, 2000.

OSMA Alliance past president Susan Paddack of Ada, Oklahoma, will be installed as President of the American Medical Association Alliance this month during the AMA's Annual Meeting in Chicago. Paddack is only the second Oklahoman to hold this national leadership position; the first was Sherry Strebel of Oklahoma City.

Over the past year, Paddack has developed an agenda for her 2000-2001 presidency that includes specific goals in the areas of fundraising, health promotion, legislation, and membership. Her past experience with the AMA Alliance includes the leadership and officer positions of Secretary; Treasurer; Field Director; Chair of the Finance Committee, the Health Promotion Committee, and the Health Awareness Promotion Award Committee; and member of the Bylaws Committee. On the state level, she has served as President and Chair of the Health Projects and Long-Range Planning Committees; on the county level, Paddack has served as President, Legislation Committee and Doctors Day Chair, Secretary, and Treasurer of the Pontotoc-Johnson County Alliance. Currently, Paddack serves as her county Alliance Treasurer, and is a member of the OSMA's Domestic Violence Committee.

Paddack is the Director of Local Education Foundation Outreach for the Oklahoma Foundation for Excellence, and is an adjunct faculty member at East Central University in Ada. She is married to Gary Paddack, MD, who specializes in internal medicine.

Paddack's 2000-2001 Presidential Agenda Includes:

- Promoting new AMA Foundation programs, such as community service seed grants and the Signature Program.
- Encouraging state and county Alliances to celebrate the AMA Foundation's 50th Anniversary during the entire fundraising year, culminating with a special event in the spring of 2001.
- Continued promotion of the children's activity resource materials, including *Hands Are Not for Hitting, I Can Choose, I Can Be Safe, Be A Winner,* and *I Can Be...*
- Updating health promotion publications, including the *Physician Spouse Series* and the *Shape Up for Life* brochure on parenting.
- Promoting committee members as resources for legislative advocacy—people who can answer questions and provide advice for getting programs up and running.
- Urging the family of medicine to register to vote in the 2000 elections.
- Encouraging Alliances to educate patients in their communities about health care legislation by providing educational information to physicians' offices.
- Communicating with state membership chairs and encouraging them to disseminate membership information to their state and county colleagues.
- Developing strategies and materials to attract additional members-at-large, RPS/MSS, international, dual-physician and male spouses as members of the organization.
- Reminding members that recruitment is the responsibility of all Alliance members.

Pelofsky to Lead National Association



Stan Pelofsky, MD AANS President-elect

Stan Pelofsky, MD, was recently elected President-elect of the American Association of Neurological Surgeons (AANS), a national scientific and educational association devoted to the development of neurological surgery. Dr. Pelofsky is the first Oklahoma physician to be elected to this national leadership position; he will be installed as President of AANS next April in Toronto.

Dr. Pelofsky's agenda for his Presidency includes continuing the postgraduate education of practicing neurosurgeons; supporting graduate medical education in neurosurgery; increasing National Institutes of Health (NIH) funding for neurosurgery; and becoming involved with the problems facing health care in this country, including social and delivery of care issues.

Of his new role, Dr. Pelofsky says, "I am incredibly proud of our state and the quality of medicine practiced in Oklahoma. It has allowed numerous physicians to go on to positions of national importance."

OSMA Convenes 94th Annual Meeting at The Westin in Oklahoma City





David Russell, MD, 1999-2000 Chair of the OSMA Board of Trustees and incoming Vice Speaker of the House of Delegates, presents awards to Attorney General Drew Edmonson (right) and Gordon Deckert, MD, (left). Attorney General Edmonson received the Don J. Blair Friend of Medicine Award; Dr. Deckert received the OSMA Community Service Award.



Gary Strebel, MD, President-elect (left), John Bozalis, MD, 1998-2000 Vice-Speaker of the House of Delegates (center), and David Nierenberg, MD, incoming Vice-Chair of the Board of Trustees (right), before the Closing Session of the House of Delegates.



Bruce Storms, MD, Speaker of the House of Delegates (right) takes a moment to visit with Jack Beller, MD, Secretary-Treasurer (left) between sessions of the Annual Meeting.



Robert Weedn, MD, OSMA President, participates in the Physicians' Campaign for a Healthier Oklahoma (PCHO) Walking Tour of the Myriad Botanical Gardens in Oklahoma City.

(below) W.F. Phelps, MD, was elected OSMA Vice President during the Annual Meeting. Dr. Phelps is pictured with Rebecca Goen Tisdal, MD, Alternate Trustee.



(below) Boyd Whitlock, MD, Immediate Past President of the OSMA, bestows the Presidential Medallion on Dr. Robert Weedn during the Presidents' Inaugural.





Dr. David Satcher, Assistant Secretary for Health and U.S. Surgeon General, was the keynote speaker at the Presidents' Inaugural held Friday evening at the Cowboy Hall of Fame.

Lieutenant Governor Mary Fallin (standing, second from right) was an honored guest at the Presidents' Inaugural. Pictured with her are Dr. Boyd Whitlock and his wife Myrna (seated, left and center), Virginia and Leonard O'Daniell (Mrs. Whitlock's sister and brother-in-law, seated, right and standing, right), and OSMA Executive Director Brian Foy and his wife, Karen.





Jay Gregory, MD, AMA Delegate (far left) presents the AMA Memorial Resolution honoring Perry A. Lambird to (from left): Chris Salyer, Suzannah Lambird Collier, Jack Collier, and Margaret Salyer.

(below) Mary Ann Couch, incoming Alliance President (left), and Cheryl Baker, 1999-2000 Alliance President (right), pictured with current AMA Alliance President Ann Hansen (center).



More photographs and proceedings of the 94th OSMA Annual Meeting will be published in the July 2000 issue of the *Journal.*

Folic Acid Knowledge and Multivitamin Use Among Oklahoma Women

Juli Montgomery, MPH; Kay Pearson, MS, RD, LD; Wanda Thomas; Edd Rhoades, MD, MPH; and Dick Lorenz, MSPH,
Maternal and Child Health Service, Oklahoma State Department of Health

Birth defects are the leading cause of infant mortality in the United States. In 1994, one out of every five infant deaths was caused by a birth defect. Unfortunately, two-thirds of birth defects are of unknown etiology.

Research has discovered that folic acid can help prevent neural tube defects (NTDs), serious birth defects of the brain and spine. It is now a recommendation for all women of child-bearing age who are physically capable of becoming pregnant to consume 400 micrograms of folic acid every day to prevent NTDs.

It is difficult, however, to obtain enough folate (the natural form of folic acid) just from food for the following reasons: few foods are high in folate, only about half the folate occurring naturally in foods is absorbed by the body, and food processing and cooking destroys 50 percent to 90 percent of folate in foods. As a result, most women only get about 200 micrograms of folic acid each day.

The Oklahoma State Department of Health (OSDH) recommends that women obtain 400 micrograms of folic acid from three sources each day: a multivitamin that contains 400 micrograms of folic acid, foods high in folate, and foods fortified with folic acid. This recommendation assures women get the correct amount of folic acid each day.

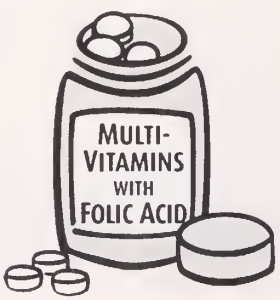
To better understand the behaviors related to folic acid and multivitamin use among Oklahoma women, data were obtained from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a collaborative effort between OSDH and the Centers for Disease Control and Prevention to reduce infant mortality and low birthweight. It is an ongoing, population-based risk factor surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and the child's early infancy among a stratified sample of mothers delivering a live birth.

Results from PRAMS show that the prevalence of knowledge of the importance of folic acid in reducing certain birth defects increased from 66 percent in 1996 to 74 percent in 1997. During 1996-1997, only 28 percent of new mothers were taking a multivitamin daily one month prior to pregnancy. Multivitamin use one month prior to pregnancy increased by only 2 percent from 1996 to 1997. Multivitamin use among mothers aged 20 to 29 was only 27 percent; this age group represented 60 percent of all live births during 1996-1997.

Other important findings from PRAMS indicated that women were more likely to report not having used a multivitamin during the month prior to pregnancy if they were: 1) less than or equal to 19 years of age, 2) less than or equal to 12 years of education, 3) unmarried, or 4) receiving public assistance. Mothers with intended pregnancies were more likely to take multivitamins prior to pregnancy compared to those whose pregnancies were unintended. The difference was more pronounced among selected demographic groups. Mothers 20 or older were more than 1.5 times as likely to use multivitamins if their pregnancy was intended rather than unintended, 33.5 percent (95 percent Confidence Interval (CI) 29.2, 37.8) and 19.4 percent (95 percent CI 15.3, 23.5) respectively. Mothers with 13 or more years of education were 2.8 times as likely to take multivitamins if their pregnancy was intended rather than unintended, 48.8 percent (95 percent CI 43.7, 53.8) and 17.3 percent (12.3, 22.3) respectively. In addition, mothers with 13 or more years of education, married, white, or receiving income from a job were more likely to take multivitamins if their pregnancy was intended rather than unintended.

Since half of all Oklahoma pregnancies are reported as unintended, assuring that these women obtain adequate levels of folic acid, even when they are not planning to become pregnant, should be a primary focus of NTD prevention activities. Other beneficial groups to target would include women between the ages of 20 to 29. This age group represented 60 percent of births during 1996-1997 in Oklahoma, but only 27 percent of this group used multivitamins one month prior to pregnancy.

At approximately 4 cents per day, multivitamins are inexpensive considering the financial and emotional costs to Oklahoma families impacted by neural tube defects. Since physicians, regardless of their specialty, are likely to encounter childbearing-age women on a daily basis, physicians are encouraged to share this important public health message to reduce birth defects in our state.



To the Editor:

Gee! What a loss for the people of rural Oklahoma. You wasted 10 years of your precious life tending to the medical needs of these poor people of rural Oklahoma. Had you stayed, and forgetting all of your complex problems regarding politics, granting agencies, Medicare, and Medicaid, you would have had time to discover these people are genuine, caring, honest, hard-working, lovable, deserving people. They become your patients, your lifetime friends who will go out of their way to help anyone in time of need. Most especially their doctor and his family.

The do "value access to health care"—they will drive distances to obtain it. You don't hear them complain because God put them in a place where adequate, good health care is unobtainable. They simply "make do."

I practiced in rural Oklahoma as a general practitioner for 50 years. It would make me very happy if I could repeat the process. I was fortunate to have specialty consultants in Oklahoma City, none of whom considered my referrals as "people without value to health care." My peers in Oklahoma City considered me on their level, so much so they elected me as a member of their Academy of Medicine. I still attend their monthly meetings.

Although now retired, my former patients are still my good friends. This I cherish so much. I miss them and they still say they miss me. I see them on the streets, at funerals, weddings, in church, and on their farms. My boys and I have hunted their lands, fished their ponds, and even shared their food. My kids grew up with their kids, attended the same schools, and loved it.

In your editorial you questioned the value of preceptorships in the rural areas. I say they should be continued. Show the "to be" physician the privilege of seeing this side of medical practice. Let them see for themselves all of the medicine that is not practiced in the "ivory tower." Let them find out that the majority of patients seen by the rural practitioner are cured by them. We see so much more of the emotional side of medicine: delivery and care of the newborn, surgery and postoperative care, geriatrics and providing hospice to the dying.

We don't always agree that our payment for services is adequate, but it doesn't upset us to the point that we lose our perspective in taking care of these wonderful, needy people.

Never fear, rural medicine will survive, thanks to the conscientious, caring, rural physician, and people will continue to drive long distances to see them, regardless of your beliefs.

Incidentally, your last two paragraphs were pure "hogwash." Mark Johnson, where are you?

J. Harold Tisdal, MD
Clinton

From the Editor:

I would remind each reader of the *JOURNAL* that the content of the editorial piece is my personal opinion. I would also remind all readers that my style is full of hyperbole and cynicism, as I find that it sharpens the point that I am trying to make. Yet, this approach sometimes "backfires."

Sometimes my style is not clear. For that, I apologize, and I will work to improve this.

I have the utmost respect for the clinicians of our state who practice in rural Oklahoma. I am working to train resident physicians who are up to the challenge. To accuse me of having an "ivory tower" mentality is to mortally wound me.

And I agree—editors of the caliber of Mark Johnson, MD, are rare, and I will continue to strive toward his level of scholarship and insight. I ask you to bear with me as I progress down that road.

J. Michael Pontious, MD
Editor-in-Chief

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New Home to the OSMA Web Site

As part of its effort to continuously improve communication with its members, the OSMA's Web site has been given a new look and a new name. Under the direction of the Council on Professional Communications, OSMA staff will be reviewing and revising the Association's Web site on an ongoing basis. The new Web site address is: www.okmed.org. Please use the form below to provide us with your current mailing and e-mail addresses to assist us in establishing our secure members-only side to the site. See you on the Web!

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In Memoriam

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Hyman J. Drell, ... July 15
Lee Bailey Word, MD July 22
Dave B. Lhevine, MD July 31
Michael Allan Houghton, MD August 16
Webb M. Thompson, Jr., MD August 20
Perry A. Lambird, MD August 25
Nolen L. Armstrong, MD September 12
George R. Randels, MD October 2
George B. Carter, MD Oetober 7
John Robert DeBiase, MD Oetober 17
Theodore Turnbull, MD Oetober 19
Sol Wilner, MD Oetober 31
Malcolm Horne, MD November 3
William Clark Cheek, MD November 11
Bill B. Elrod, MD November 17
Donald E. Johnson, MD November 18
Allen E. Grcer, MD November 19
Beverly Colvin Chatham, MD Deeember 2
Norman A. Cotner, MD Deeember 3
Alan Knight Braly, MD Deeember 9
Wilson David Steen, PhD December 12
James Thermon McInnis, MD Deeember 18
Douglas Lyons Polk, MD Deeember 19
Thomas S. Llewellyn, III, MD December 26
John Preston MeDaniel, MD December 27
Joe Earle Tyler, MD Deeember 31

2000

Hwan X. Youn, MD.....January 2
Donald Charles Barney, MD.....January 4
Charles E. Cook, MD.....January 13
Lynn H. Harrison, MD.....January 16
Kenneth C. Hoffman, MD.....January 17
Riehard E. MeDowell, MD.....January 17
Orval L. Parsons, MD.....January 29
James William White, MD.....February 1
Harry L. Deupree, MD.....February 3
James L. Nieholson, MD.....February 3
Leo Meeee, MD.....February 5
Homer A. Rupreeht, MD.....February 6
William G. MeCreight, Sr., MD.....Mareh 10
Armond H. Start, MD.....Mareh 30
Billy E. Blevins, MD.....April 3
Willis E. Lemon, MD.....April 21
Roy A. Lawson, MD.....April 22
Benjamin F. Gorrell, MD.....April 29
Adolph N. Vammen, MD.....May 8

Obituaries

Willis E. Lemon, MD
1917-2000

Willis E. Lemon, MD, died April 21, 2000. Born in La Grange, Illinois on July 6, 1917, Dr. Lemon graduated from the University of Minnesota Medieal School in 1943. From 1944 to 1946, Dr. Lemon served in the United States Navy. He was a member of the Phi Rho Sigma Medieal Soeiety Fraternity, Fellow Emeritus of Ameriean College of Radiology, and, sinee 1985, a life member of the Oklahoma State Medieal Assoeiation.

Roy A. Lawson, MD
1924-2000

Roy A. Lawson, MD, died April 22, 2000. Dr. Lawson was born July 10, 1924 in Kansas City, Kansas; he earned his medieal degree from the University of Kansas in 1949. Dr. Lawson served aetive military duty in the United States Army from 1943 to 1945, and again from 1951 to 1953. In 1991, Dr. Lawson beeame a life member of the Oklahoma State Medical Association.

Benjamin F. Gorrell, MD
1919-2000

Benjamin F. Gorrell, MD, died April 29, 2000. Born June 28, 1919 in Tulsa, Dr. Gorrell reeeived his medieal degree from the University of Oklahoma School of Medieine in 1945. He served aetive duty in the United States Army during World War II, and was a life member of the Oklahoma State Medieal Assoeiation sinee 1989.

Adolph N. Vammen, MD
1919-2000

Adolph N. Vammen, MD, died May 8, 2000. Dr. Vammen was born July 17, 1919 in Osakis, Minnesota, and earned his medieal degree from the University of Oklahoma in 1944. He served in the United States Army from 1942 to 1944 and 1946 to 1948, aehieving the rank of Captain. Dr. Vammen beeame a life member of the Oklahoma State Medieal Assoeiation in 1992.

Classifieds

Classified ads are 50 cents per word, with a minimum of $25 per ad. A word is one or more characters bounded by spaces. Box numbers will be assigned upon request and will add 6 words to the total. ***Payment must accompany all submissions.*** Orders will not be accepted via telephone or fax. Mail ad with payment to OSMA *Journal*, 601 West I-44 Service Road, Oklahoma City, OK 73118. Deadline is the first of the month prior to the month of issue (for example, March 1st deadline for the April issue).

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Course offerings from OSMA Accredited Institutions

Duncan Regional Hospital: Amy Wade 580/251-8648

June	27	Clinical Guidelines in the Treatment of ENI Diseases: Part III (The Ear)	Noon	1 hour

Integris Baptist Medical Center: Donna Schoenfelder 405/949-3284

June	2	Tumor Board	7:00 am	1 hour
June	2-3	Burn Care Conference: "Beyond Survival" @ Hilton Northwest	7:00 am	4 hours
June	3	"Recent Changes in Urology"	7:00 am	1 hour
June	9	Cancer Conference	7:00 am	1 hour
June	14	"Surviving & Prospering In Practice Beyond 2000": Risk Management Dept.	6:30 pm	3 hours
June	14	"Post Op Pain for Cancer Patients"	7:00 am	1 hour
June	15	"Post Op Pain & Acute Pain Management"	7:00 am	1 hour
June	16	Tumor Board	7:00 am	1 hour
June	16	OB/GYN: TBA	7:00 am	1 hour
June	23	Tumor Board	7:00 am	1 hour
June	30	Tumor Board	7:00 am	1 hour

Mercy Health Center: Debbie Stanilla 405/752-3806

June	1	CPR: "A Framework for Decision Making"	12:15 pm	1 hour
June	6	Multidisciplinary Breast Conference	7:00 am	1 hour
June	8	"Non Hypertensive Use of Angiotersin Receptor Blockers"	12:15 pm	1 hour
June	13	Neuroscience Institute Lecture: TBA	7:00 am	1 hour
June	15	"Treating Sprains, Strains, and Sports Injuries"	12:15 pm	1 hour
June	21	Ethics for Lunch	Noon	1 hour
June	22	"Chronic Headache Pain"	12:15 pm	1 hour
June	29	"Chronic Pain Management"	12:15 pm	1 hour

St. Anthony: Sandy Coury 405/272-0411

June	1	Cancer Conference: TBA	7:00 am	1 hour
June	5	Grand Rounds: "Medical Penmanship"	8:00 am	1 hour
June	8	Cancer Institute Oncology Grand Rounds: TBA	7:00 am	1 hour
June	12	Heart Conference Presentations: TBA		
June	15	Cancer Conference Presentations: TBA	7:00 am	1 hour
June	15	Behavioral Medicine Share Presentations: "Relationship As A Therapeutic Undertaking"	Noon	1 hour
June	19	Medicine Grand Rounds: "Chronic Pain"	8:00 am	1 hour
June	21	"Congenital Anomalies In Utero Diagnosed With Ultrasound Part II"	Noon	1 hour

St. John Medical Center: Gail Hilst 918/744-2875

June	1	Critical Care Conference: Neuro Exam	Noon	1 hour
June	6	Critical Care Conference: Angina Pectoris	Noon	1 hour
June	15	Critical Care Conf.: Continual Renal Replacement	Noon	1 hour
June	20	Critical Care Conference: Syncope	Noon	1 hour
June	22	Critical Care Conf.: Wounds & Burns	Noon	1 hour
June	27	Critical Care Conference: Case Review	Noon	1 hour
June	29	Critical Care Conference: Trauma	Noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator at 405/843-9571 or 800/522-9452.

Congratulations, Susan!

For those of you who do not know Susan Paddack, or for those who do not appreciate what an accomplishment it is for Susan to be elected AMA Alliance President, I would like to share a few observations.



Susan Paddack, AMA Alliance President (left) and Mary Ann Couch, OSMA Alliance President

Conventional wisdom would have eliminated Susan from attaining this office. After all, Sherry Strebel, also from Oklahoma, was AMAA President just ten years ago. It isn't "our turn" again. So much for conventional wisdom! Cream rises to the top.

On the several occasions I have mentioned Susan to leaders from other states, whether on the telephone, or in Chicago at Confluence, or at the Annual Meeting, the general reaction to her name is one of joy. The comments usually begin with acknowledgement of her genuineness, her work ethic, and what a pleasure it is to know her. With Susan, what you see is what you get.

This office is not an honorary or figurehead position. In the ten years since Susan was OSMA Alliance President, she has proven her abilities in many capacities on the national level. She is always upbeat and energetic, and that sparkle in her eyes is a result of her gleaming intelligence shining through.

There is much more to Susan than her involvement in the Alliance. Like a diamond, she has many facets. Her family, church, jobs, and other organizations have all gotten a share of her attention.

I am proud to know her, and to call her my friend.

Congratulations, Susan!

Mary Ann Couch
2000-2001 OSMA Alliance President





Susan Paddack, shown (above) with Dr. Jay Gregory, Chair of the AMA Delegation, and The Extinguisher (right), will be installed as AMA Alliance President on June 13 during the AMA Annual Meeting in Chicago.

The Last Word

"Take Care II" Campaign to Launch in Central, Western Oklahoma in July

Following a highly successful debut in January of this year, another "Take Care" campaign has been scheduled for July 5-25 in Central and Western Oklahoma by Oklahoma City's KWTV-Channel 9. Once again, the OSMA's Physicians' Campaign for a Healthier Oklahoma will be a sponsoring partner in the campaign.

The "Take Care" campaign is intended to help save lives by placing important medical information in a EMS file where emergency personnel can easily find it. The EMS file is a large amber vial containing a health questionnaire that lists vital medical information and is stored inside the participant's refrigerator. Special decals are placed on the front door of the home to alert medical personnel that the information is available. The program will be promoted through a series of public service announcements and news stories.

During the January campaign, more than 21,000 vials were distributed, and OSMA physicians in the Channel 9 viewing area were besieged by requests from patients. In addition, the OSMA staff received dozens of calls from senior centers, hospitals, fire and rescue departments, civic groups, service clubs, and many others, all wanting to participate in the program.

The EMS containers will be available to OSMA physicians on a first-come, first-served basis. For more information, please contact Brenda Hays, OSMA Communications Director, or Johnna Kienholz, Communications Assistant, at 405/843-9571 or 800/522-9452.

Take Care

NEWS 9 OKWTV

THE SPIRIT OF OKLAHOMA

Oklahoma Health News Network Debuts

The Oklahoma Health News Network, the OSMA's new public service project, made its debut in May with the first health-related news stories and health tips sent to Oklahoma radio stations. As part of the Physicians' Campaign for a Healthier Oklahoma, and conducted under the ageis of the Public Relations Council, the Oklahoma Health News Network will produce a series of 60-second health news stories and 30-second health tips and send them free-of-charge for airing on Oklahoma's radio stations each month. The health news stories will feature sound bites or "actualities" of OSMA members discussing the various topics.

Preventive Care Resource Made Available by AHRQ

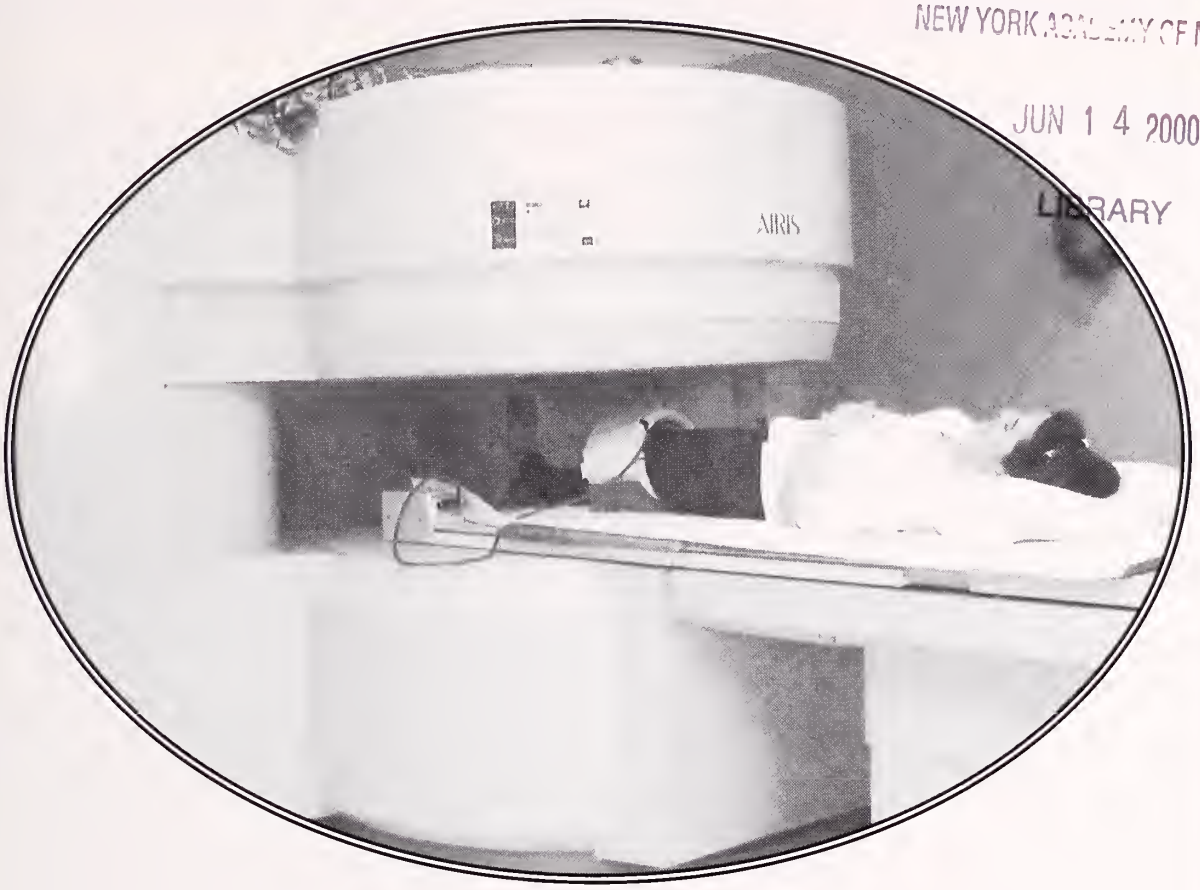
The Agency of Healthcare Research and Quality's Put Prevention Into Practice program has released *Staying Healthy at 50+*, a booklet designed to encourage patients to actively participate in their preventive care. It provides charts to track personal health information, questions to ask health care providers, and information on osteoporosis, vision problems, hearing loss, menopause, blood pressure, diabetes, and other aspects of personal health. The guide may be viewed on the AHRQ Web site at www.ahrq.gov/ppip/50plus/.

Keep An Eye On Those Little Ones!

The American Academy of Pediatrics (AAP) is reminding parents that infants and toddlers must be monitored closely while in the water because of the risk of drowning. The AAP advises that an adult be no more than an arm's length away from an infant or toddler in and around water, even if the child has developed some water skills or become comfortable in the water. Drowning is a leading cause of unintentional injury and death in children under the age of four, and it is the number one cause of death among children ages one and two in Arizona, California, Florida, and Texas—all pool-popular states. —*USA Today, April 4, 2000*

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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

The 2000 OSMA Annual Meeting



INSIDE:

Isolation of Fungi from Rose Bush Thorns 271

Alcohol Consumption Among the Elderly 275

Proceedings of the 2000 OSMA Annual Meeting 289

News 374

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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

JULY 2000 VOL. 93, NO. 7

EDITORIAL

On Democracy 267
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE

Advocacy, Not Apathy 269
ROBERT J. WEEDN, MD, DUNCAN

SCIENTIFIC

Isolation of Fungi from Rose Bush Thorns 271
D.J. FLOURNOY, PHD, OKLAHOMA CITY; J.B. MULLINS, OKLAHOMA CITY; R.J. MCNEAL, OKLAHOMA CITY

SPECIAL

Alcohol Consumption Among the Elderly: Dispelling the Myths 275
LAURA J. TIVIS, PHD, OKLAHOMA CITY; EDWARD N. BRANDT, JR., MD, PHD, OKLAHOMA CITY

CONNECTED CLINICIAN

Medschool.com: Opportunity or Threat? 287
CHRIS CANDLER, MD, OKLAHOMA CITY

ANNUAL MEETING

Proceedings of the 2000 Annual Meeting of the Oklahoma State Medical Association 289

NEWS

Oklahoma Physicians Honored by OU College of Medicine, 374...Calhoon Named OAFP Family Physician of the Year, 375...Oklahoma Physician Named to Cancer Liaison Program, 375..."Jawbones" and "Sawbones" Tee It Up for Charity, 375

DEPARTMENTS

Obituaries, 379...In Memoriam, 379...CME, 382...Alliance, 383...The Last Word, 384



ABOUT THE COVER

Photograph of an Oklahoma City fireworks display by Robert Smith, MD.

Art Direction by Transcript Press, Norman

OKLAHOMA CITY CLINIC

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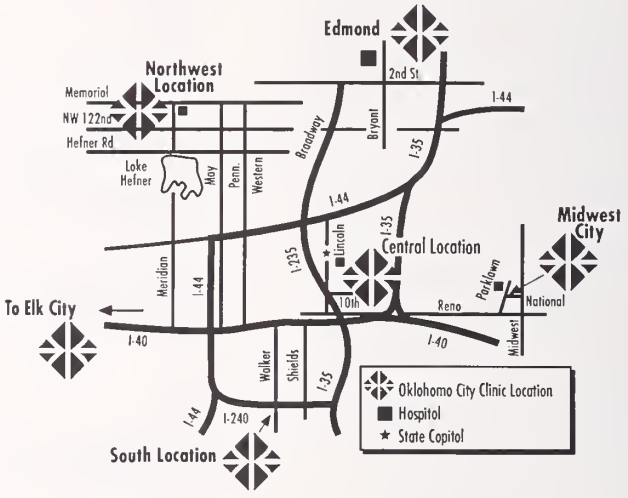
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On Democracy

It is the time of year in which the proceedings of the Annual Meeting of the Oklahoma State Medical Association are published. It is the time of year that the membership can review the work of the Association. It is the time of year when you can find out about what is happening in your area of interest.

Be careful—it might be disappointing or disturbing.



The sad fact is that this material will often be ignored by the membership, "chalked off" as being irrelevant, boring, or misplaced. I often wonder if the process is worthwhile. Who will take their precious time to look closely at what is transpiring with the OSMA?

And then there is the way that the organization deals with the controversial issues, such as our internal argument about unification verses de-unification. The movement to de-unify membership in our Association was once again debated, discussed, and voted on, and the decision of the House of Delegates was to maintain a unified membership.

This topic continues to be a fulcrum that divides the membership, pitting you against me, them against us.

Many have voted with their feet; no longer will they support the organization because of the decision. Others will continue to work to change the current rules, diverting their attention from topics and organizational needs that are more important to Oklahoma medicine. There will be others who will attempt to micromanage local administration of the Oklahoma State Medical Association, attempting to sway the focus of the Association to their perspective.

Such is the nature of human beings.

We find that rules and regulations are necessary evils, yet we take comfort in the evils that we have created. If we are going to set up the rules of conduct and the regulations, we are going to design a system that protects the entrenchment of current power. We don't tolerate the swings of moods or influence of the membership—we would rather protect the status quo of our organization.

Would someone tell me: is protecting the "status quo" a positive stance? Is further entrenchment of the current power in this organization of benefit to the organization?

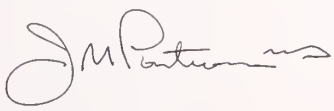
As a child of the 1960s, civil disobedience was seen as the norm. With my aging, I have mellowed a bit. I see the comfort that comes from the predictable…yet I perceive that our current "status quo" may not be the vehicle to get the Oklahoma State Medical Association down the road.

Look at our House of Delegates. Although much of the House is made up of representatives from the "rank and file" county societies from throughout our state, the remainder of the House of Delegates is made up of the upper leadership of our organization. The upper leadership is entrenched, rarely changing, rarely opening up to outsiders.

I can only sense a bit of frustration among the membership. I have no real data. But the organization is becoming more and more gray-haired (and yes, your editor is in this boat as well). We find ourselves a bit confused about why younger physicians are not joining this organization. Seems that many younger physicians have to be "coerced" into becoming members at the county medical society level, and rarely do these members venture beyond this level of involvement. The reputation of OSMA among residents and medical students is one of confusion in understanding the relevance of the organization.

Is this the nature of professional organizations?

What are we going to do for an encore?



J. Michael Pontious, MD
Editor-in-Chief

"If we are going to set up the rules of conduct and the regulations, we are going to design a system that protects the entrenchment of current power."

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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Advocacy, Not Apathy

As individual physicians, we are frequently overwhelmed by the problems of our patients and our practices. Nevertheless, it is in the caring for our patients in a conscientious and compassionate manner—by treating and teaching each patient with our hearts as well as our heads—that we create advocacy for ourselves and for our profession. However, patient and physician advocacy—on an individual basis—is, by its nature, quite limited.



As physicians, we share a common bond of education, experience, and commitment and have noble aspirations. We took the oath of Hippocrates, stating that while we would always put our patients first and foremost, we would also take care of our fellow physicians and their families—a pledge that is incorporated in the mission statements of both the OSMA and the AMA.

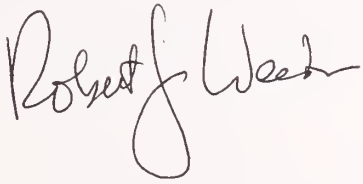
Ultimately, organized medicine is about patient and physician advocacy as a united effort. At every level—whether county, state, or national—our organizations must function in an interdependent fashion in order to achieve the greatest success. However, sometimes—because of our frustrations with our daily problems—we may find ourselves losing sight of the big picture and forget the simple truth: *We can either pull together or pull apart. We can be united or divided.*

Physicians are trained to be self-reliant and self-confident in order to take care of their patients, but sometimes these characteristics can also make it harder for us to come together in a united way unless there is an external threat. And while not as obvious, perhaps, as in the days of the push for socialized medicine or national health insurance, we are facing threats to both our patients and our profession today in the form of regulation, gatekeeping, etc., as well as in the divisiveness within our own house or family of medicine. Compounding matters, we must also contend with the greatest threat to any endeavor: simple apathy.

Your OSMA is not doing the same old things in the same old ways—and has not been for the last few years. Our goals and objectives have been better defined and refined as part of an ongoing long-range planning process, reviewed yearly, that was endorsed and approved by your OSMA House of Delegates. Your OSMA has become progressively proactive instead of reactive, but this effort is intended to complement our component medical societies rather than to compete with them. And it is imperative that we be mutually supportive in this regard.

We must work through any differences with mutual love and respect. We can clearly accomplish more in a cooperative effort than we can alone. Toward that end over the next few weeks, I will be communicating with each county medical society president, seeking their input as well as nominees for various OSMA councils and committees.

Your OSMA leadership and administrative staff will be working hard for you in the coming year. Please help yourselves, your colleagues, and your patients by joining this effort. The results will be synergistic, but each of us must carry our own share of the workload. As someone once said, *"It takes the best in each of us to make the best world for all of us."*



Robert J. Weedn, MD
OSMA President

"Physicians are trained to be self-reliant and self-confident in order to take care of their patients, but sometimes these characteristics can also make it harder for us to come together in a united way unless there is an external threat."

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Isolation of Fungi from Rose Bush Thorns

D.J. Flournoy, PhD; J.B. Mullins; R.J. McNeal

Rose bush thorns from plants in the Oklahoma City area were cultured to determine the prevalence and species of fungi present. One hundred fifty isolates grew from thorns on 103 plants. All thorns harbored at least one species, while one thorn had five species of fungi. Of the 21 fungal species isolated, all are known human pathogens, although most rarely cause disease in immunocompetent individuals. *Alternarium sp., Bipolaris sp., Aspergillus niger, Curvularia sp.,* and *Fusarium sp.* were the most common fungi, accounting for 75% of the isolates. *Sporothrix schenckii,* an organism often associated with rose bushes, was found on thorns of only two plants. Findings of this study suggest that since fungi are common inhabitants of roses, individuals who experience rose-thorn punctures are at increased risk of acquiring fungal infections, especially if they are immunocompromised.

Introduction

Puncture wounds are important vehicles in the transmission of pathogenic microorganisms. For the gardener, punctures can easily occur via thorned plants like roses, berry vines, and pyracantha bushes. Thorned plants are much more likely to penetrate the skin than non-thorned plants when gloves are not worn. One group of microorganisms that is commonly found on plants is fungi. However, the occurrence of fungi can vary depending on factors like the geographical area of the country and the environment (eg, temperature, humidity, nutrients). For example, *Coccidioides immitis* is endemic in the soil and some plants of the San Joaquin Valley in California, preferring arid to semiarid climates, hot summers, few winter freezes, low altitude, and alkaline soils.[1] On the other hand, *Histoplasma capsulatum* is endemic in the central United States and is more prevalent in areas with heavy avian or bat excrement.[2]

In addition to environmental and geographical factors, some fungi have been associated with certain plants. For instance, *Sporothrix schenckii*—which causes chronic cutaneous sporotrichosis or "rose handler's disease"—has been associated with a number of plants including roses,[3-6] sphagnum moss,[7-10] timber,[11] and mushrooms.[12] The geographical occurrence of *S. schenckii* has been suggested to be higher in the plains states than the west coast region[13] and several reports have noted outbreaks in Oklahoma.[14-15]

Since roses are one of the most popular thorned plants of gardeners, we were interested in the fungal flora of roses; however, little comprehensive information was available on this subject. In addition, we were curious if the fungal flora of healthy and unhealthy plants was similar. We also wanted to know how often *S. schenckii* occurred on rose thorns, and if nursery workers had heard of sporotrichosis. Our interest in sporotrichosis was stimulated by a number of local studies dealing with immunity, diagnosis, and treatment.[16-21] With the above factors in mind, a study was performed to determine the fungal flora of rose thorns from plants in the Oklahoma City metropolitan area.

Materials and Methods

One hundred three rose bushes from 11 Oklahoma City metropolitan area nurseries and gardens on the University of Oklahoma campus in Norman were sampled. Plants were sampled from September 6 through November 11, 1999. The following information was collected: name of the nursery, variety of rose, ambient outside

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Table 1. Molds Isolated from 103 Rose Thorns

Organism	Number of isolates (%)
Alternarium sp.	45 (30.0)
Bipolaris sp.	25 (16.7)
Aspergillus niger	23 (15.3)
Curvularia sp.	11 (7.3)
Fusorium sp.	8 (5.2)
Acremonium sp.	4 (2.7)
Aspergillus fumigotus	4 (2.7)
Aureobasidium pullulons	4 (2.7)
Nigrosporo sp.	4 (2.7)
Aspergillus versicolor	3 (2.0)
Unidentified	3 (2.0)
Helminthosporium-sp.	2 (1.3)
*Sporothrix schenckii**	2 (1.3)
Choetomium sp.	2 (1.3)
Trichodermo sp.	2 (1.3)
Poecilomyces sp.	2 (1.3)
Stochybotrys sp.	1 (0.7)
Arthrinium sp.	1 (0.7)
Clodophiolapharo corrionii	1 (0.7)
Exaphialo dermotitidis	1 (0.7)
Clodophiolophoro bontiono	1 (0.7)
Penicillium sp.	1 (0.7)
Totol	150

* *S schenckii* grew from two plants that were from different nurseries

temperature and relative humidity, and appearance of the plant (eg, did plant leaves appear healthy? did leaves appear to have been sprayed to prevent plant disease?). Eleven nursery workers also were asked if they had ever heard of sporotrichosis.

Two to five rose thorns were removed from each plant aseptically, using sterile forceps. The thorns were then placed in newly purchased/unused freezer storage bags during transit to the Microbiology Section. The time between collection and culture inoculation was one to three days. Routine fungus cultures were performed by aseptically transferring rose thorns to the surface of potato flake agar slants in 18 × 150 mm screw-cap glass culture tubes.[22,23] Cultures were incubated at 30°C for four weeks in an atmosphere of room air with a relative humidity between 60% to 75%. Fungi were identified microscopically using standard procedures.[23-26]

For quality controls, the insides of fifteen new/unused storage bags were swabbed with sterile water-moistened cotton swabs and cultured for fungi. The cultures were negative. In addition, each new batch of potato flake agar slants was inoculated with a stock strain of *Sporothrix schenckii*, incubated at 30°C and observed periodically to insure the media would support fungal growth. In each batch sampled, the medium supported fungal growth.

Results

One hundred fifty mold isolates grew from thorns on 103 rose bushes that were collected from 11 Oklahoma City metropolitan area nurseries and gardens at the University of Oklahoma in Norman (Table 1). Three thorns had molds that were not identified due to "sterile hyphae." Seventy-two of 103 thorns had one fungus isolate, 18 had two, 11 had three, one had four, and one had five. Thorns ranged in length from 0.2 cm to 1.3 cm.

Of the 103 plants sampled, the leaves of seven from one nursery appeared healthy but discolored, presumably due to sprays used to inhibit plant pathogens. Fungi isolated from these seven plants included *A. niger*, *Alternarium sp.*, *Bipolaris sp.*, *Fusarium sp.*, and one unidentified mold. We were unable to find any statistical correlation between fungal isolate and rose bush variety, date collected, temperature, relative humidity, nursery, or city. However, of the five most common isolates (Table 1), *Alternarium*, *Bipolaris*, *Aspergillus niger*, and *Curvularia* were widely distributed among at least two-thirds of the nurseries, and *Fusarium* (isolated from eight plant thorns) was found in one-fourth of the nurseries. The remaining fungi were much less widely distributed. Only one of 11 individuals who worked at the 11 nurseries had ever heard of sporotrichosis, and this person was unaware of the symptoms or cause of the disease.

Twenty-seven of 103 plants had leaves that looked unhealthy (eg, dry/burnt, yellow, black spots). Fungi from thorns of unhealthy plants were compared with healthy plants. *Alternarium sp.* was the most common isolate from both healthy and unhealthy plants. There was no statistical difference among isolates from healthy and unhealthy plants as determined by Chi-square analysis, with one degree of freedom, and a level of significance $p < 0.05$.

Discussion

The most important finding in this study was that all rose thorns harbored fungi, the vast majority of which are opportunistic pathogens. Therefore, it appears that if an individual receives a rose thorn puncture, he/she is virtually assured of cutaneous inoculation with an opportunistic fungus. In addition, if the thorn remains in the skin, the presence of the foreign body could decrease the number of organisms required to cause infection by over 1,000-fold.[27] The last and perhaps most critical factor in determining if infection arises is the immune

status of the thorn-puncture recipient. Those who are immunocompromised are more likely to become infected.

In our opinion, the potential for fungal infection from thorn puncture is greater than one might initially perceive since there are many thorned plants, individuals exposed to thorns, and immunocompromised individuals. First, it seems reasonable to assume that similar fungi might inhabit a variety of thorned plants (eg, roses, berry vines, and pyracantha bushes) and even plants with sharp pointed leaves, like holly bushes. Second, although the percentage of people who receive puncture wounds is likely to be small, the cumulative number is probably large since numerous people are intimately exposed to plants (eg, nursery persons, farmers, florists, outdoor laborers and enthusiasts, forresters, environmentalists). Third, the number of people who are immunocompromised is large and includes those with altered splenic function or splenectomy, bone marrow failure, malignancies, allograft recipients, some genetic disorders (eg, diabetes mellitus, autoimmune diseases), acquired immune deficiency syndrome, pregnant women, neonates and young children, the elderly, malnourished, abusers of drugs and alcohol, and those on steroids or other immunosuppressive agents. In addition, since infectious diseases occur among people with no known immune deficits, others also may be at risk. Therefore, one might conclude that there are many people who are at increased risk of acquiring fungal infection via thorn puncture. On the other hand, most people who receive thorn punctures probably do not become infected, undoubtedly because they have intact immune systems and/or virulence of fungi is low.

When infections occur, they are usually self-limited. For the superficial mycoses, predispositions to infection include natural or iatrogenic immunosuppression and possibly genetic factors.[28] Cell-mediated immunity appears to be particularly important for combating fungi, yet a number of defects in immunological responses have been reported.[29] Generally, organisms eliciting a lesser inflammatory response are more likely to cause chronic infections.

The organisms we isolated from rose thorns can cause disease in immunocompromised people. For example, one study on organ transplant recipients noted the following fungal pathogens: *A. fumigatus*, *A. niger*, *Chaetomium*, *Trichoderma*, *Alternaria*, *Paecilomyces*, *Fusarium*, *Acremonium*, *Bipolaris*, and *Sporothrix schenckii*,[30] all organisms isolated in this study. Of the 21 fungal species isolated in this study, all are known human pathogens, although some rarely cause disease.

Since *S. schenckii* has been associated with rose plants,[3-6] we were particularly interested in finding out how often a rose gardener or nursery worker was likely to be exposed to *Sporothrix schenckii*. In this study, *S. schenckii* only occurred on 1.3% of the thorns, an unexpectedly low prevalence suggesting that its acquisition from roses is not common in the Oklahoma City area. However, the low prevalence in our study may have been influenced by other factors, like the season of the year.

Rose plants are notoriously susceptible to fungal diseases, especially during periods of high humidity.[31] Although none of the fungi we isolated were listed as common rose plant pathogens, some were pathogens for other plants.[31] For example, *Fusarium sp.* causes wilt for a variety of plants including asters, mums, marigolds, peony, and tulips, and it causes blight in many varieties of grass. Also, *Helminthosporium sp.* causes leaf spot in some grass varieties. Therefore, some of the organisms we found on roses can be both plant and human pathogens.

Finally, it is important to discuss ways of reducing the risk of thorn puncture. For immunocompromised individuals, the consequence of thorn puncture (ie, fungal infection) could be life-threatening. Therefore, avoidance of gardening would be the safest way to eliminate the risk. On the other hand, some individuals may choose to garden cautiously (eg, do not prune and handle plants) rather than give up gardening. One study mentioned that wearing cotton or rubber gloves reduced sporotrichosis obtained from handling sphagnum moss.[14] However, acquisition from sphagnum moss is quite different from rose thorns. Indeed, some rose thorns are longer than 1 cm in length, composed of a hard woody substance, and could easily penetrate rubber, cotton, or perhaps even leather gloves. Nevertheless, we recommend wearing thick pliable leather gloves, long-sleeve shirts, long pants, and leather boots for protection when working around rose bushes or other thorned plants or plants with sharp leaves. Another ploy is to eliminate plants with sharp protuberances from the garden. For the diehard rose enthusiast, thorns can be carefully knocked off of rose bush stems with a blunt object without seriously damaging the plant in most instances. Efforts should be made to alert immunocompromised people who are exposed to thorned/sharp plants as to the possibility of fungal infection following puncture. If one is

punctured, it is important to remove the thorn (ie, foreign body), then cleanse and disinfect the puncture site as soon as possible. Lesions associated with a puncture should be reported to the person's health care provider. We hope that physicians will consider the findings of this study when taking patient histories on individuals who may have experienced thorn punctures, especially those who are immunocompromised. J

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Alcohol Consumption Among the Elderly: Dispelling the Myths

Laura J. Tivis, PhD; Edward N. Brandt, Jr., MD, PhD

Do old people drink? Community surveys suggest that alcohol consumption is lowest among elders compared to any other age group, and that patterns of drinking are relatively stable across mid-to-late life. But is this an accurate portrayal of those individuals seeking medical guidance? In other words, what is the likelihood of alcohol abuse or misuse among the typical hospital, outpatient clinic, or emergency room patient? How difficult is it to spot potential alcohol misuse among the elderly? The purpose of this paper is to address these questions and to assist physicians of the medical community in the important function of early detection and prevention of alcohol abuse/misuse in patient populations.

Surveys and Alcohol Consumption Patterns Among the Aging: What Do the Data Say?

Over the years, several national surveys have been conducted within the United States and abroad to determine consumption patterns among individuals of all ages. Within this country, data generated from the National Alcohol Surveys (NASs), conducted in 1984 and 1990,[1] have provided large amounts of data including estimates of demographic characteristics associated with "current drinkers," "weekly drinkers," and "5+ drinks" drinkers. Highlights of the NASs suggest the following: 1) There is a significantly lower proportion of current, weekly, and heavier (5+ drinks) drinkers among individuals age 60 and older than among any other age group, 2) among women age 60 and older, the proportion of current drinkers decreased between 1984 (49%) and 1990 (37%), 3) older men drink more frequently and in greater quantities than older women, and 4) no significant changes (between 1984 and 1990) were observed among elderly weekly (<18%) or heavier drinkers (<1%). These data imply that rates of heavy drinking are relatively low among the aged, patterns of drinking are stable across mid-life, and that some decreases in consumption are evident.[1]

A more recent survey was conducted to identify rates of alcohol abuse and dependence in various age groups. In 1992, the National Longitudinal Alcohol Epidemiologic Survey assessed rates of alcohol abuse and dependence as defined by the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).[2] Survey results indicated that less than 1% of individuals over the age of 65 (0.64%) met criteria for alcohol abuse and dependence. In summary, these data, as well as those from other surveys, suggest that rates of problem drinking—as well as alcohol consumption in general—are relatively low among our nation's elderly.

Do these low rates of alcohol use/abuse convey that concern for elderly drinking is unnecessary? While it is possible that the generally low rates and the noted decreases in drinking with age represent the absence of a problem among the elderly in our society, it is equally likely that surveys are not able to provide the "big picture." For example, the low rates of alcohol use and abuse may represent a cohort effect. In other words, it is possible that individuals surveyed grew up during a time when alcohol was unavailable, or the use of alcohol was forbidden within their social group, and therefore influenced their decision not to drink as adults. If in fact a cohort effect does exist, we would expect rates to change (decline or increase) as new cohorts are sampled. Whether or not a change will occur remains to be seen.

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An equally likely explanation for the low rates concerns morbidity and mortality issues. It is conceivable that elderly heavy and/or problem drinkers failed to be included in the surveys because they have "died off" from complications of alcoholism. This is not an entirely unreasonable explanation, as only relatively healthy individuals are typically included in household surveys. Hospitalized, institutionalized, and homeless individuals are generally not a part of the populations surveyed.

Obviously, drinking practices and patterns are likely to differ from region to region. Thus, low reported rates of alcohol use/abuse might be a reflection of geographic sampling patterns. Adams[3] found considerable geographic differences within the United States with regard to elderly drinking. For example, she reported that 81% of men and 65% of women surveyed in East Boston consumed alcohol within the year. However, only 61% and 41% of Iowa men and women, respectively, consumed alcohol beverages. Other variations from survey to survey include differences in definitions of "older." For example, studies that consider drinking behavior among individuals aged 55+ are likely to find considerable rate differences from those assessing consumption among individuals aged 75+. Finally, limitations of self-report data are of considerable importance. Some researchers estimate that denial of alcohol use/abuse is more common among the elderly than among other age groups.[4] This suggests that large scale quantity and frequency estimations among older individuals may be unrepresentatively low.

Despite the seemingly low rates of use and abuse of alcohol suggested by available survey data, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has taken the following stand:

> *"As the population continues to age, assessment of drinking patterns and consequences of alcohol use among older persons will become increasingly important...lower rates of alcohol use and fewer reports of alcohol-related problems in the elderly than in younger age groups can no longer preclude the design and implementation of epidemiologic (and other) studies of alcohol use and abuse among the elderly in this country."*[1]

Clearly, the issue of alcohol consumption is important and warrants the attention and concern of researchers, educators, and physicians.

The Challenge of Identifying Elderly Problem Drinkers

Studies of hospitalized and outpatient populations suggest that the incidence of alcoholism among elderly patient groups is significantly higher than among the general community. In a review of the early literature, Liberto, Oslin, and Ruskin[5] revealed that from 20% to 50% of elderly patient groups may have symptoms of alcohol dependence. Given the effects of heavy drinking on general health and increases in morbidity/mortality rates among problem drinkers, it should not be surprising to find considerably higher rates of alcohol problems among elderly patient populations compared to elderly community groups.

In a study of elderly emergency department admissions, Adams and her colleagues[6] observed that 24% of persons aged 65 and older admitted to the emergency department over the course of about seven weeks met lifetime criteria for alcohol abuse or reported problem drinking. Fourteen percent met criteria for current abuse of alcohol. Compared to non-abusers, abusers were found to be slightly younger (mean age of 71 ± 6 years compared to 74 ± 7 years, $p < .03$) and were more likely to be male (86% compared to 36%, $p < .001$).

Strikingly, of the 29 current alcohol abusers detected by these researchers, only six (21%) were identified as alcohol abusers by the emergency department physician. These data suggest that alcohol use disorders are either extremely difficult to identify among the elderly, or that physicians tend to be resistant to assigning a diagnosis of alcohol abuse to elderly patients. It is important to note that the criteria used to determine current abuse patterns in this study were relatively objective measures of consumption and drinking patterns [the CAGE questionnaire, self report of past/current drinking problem, reported frequency of alcohol consumption, and time since last drink]. Had physicians administered these or similar items as part of their intake interview, it seems likely that a greater number of alcohol use disorders would have been detected. It is not clear whether or not physician resistance is a major contributor to low detection rates. However, Liberto and his colleagues[5] found that physicians were less likely to diagnose elderly patients, compared to their younger counterparts, with alcohol abuse/dependence.

Without specific alcohol use questionnaires with which to assess abuse and dependence issues, problem drinking can be difficult to dis-

cern. One explanation concerns the clinical presentation of the elderly patient. Many older drinkers present to the emergency department or to the general practitioner with recurring falls, signs of self-neglect (including malnutrition), and/or aggressive behavior patterns.[7] Cognitive impairment, confusion, and suspiciousness may be seen and attributed to Alzheimer's or other dementing disease processes. Medical problems such as liver and cardiovascular disease, peptic ulceration, and seizures are seen as potential signs of alcohol abuse in younger patients, but frequently regarded as symptoms of normal aging among the elderly.

Elderly alcoholics frequently present with signs of depression. At its worst, suicide may have been attempted. Some researchers have attributed drinking behavior among aging alcoholics to depression thought to be associated with, or secondary to, specific psychosocial changes that occur with advancing age. Common changes include retirement, loss of a spouse (bereavement), and the physical changes that accompany aging. One study has examined the relationship between drinking history and current psychiatric co-morbidity. Saunders et al[4] reported that individuals with a drinking history were several times more likely than individuals with no history of drinking to have current psychiatric diagnoses. The most common current problems were depression and/or dementia. To determine whether or not a psychiatric problem precipitated the drinking, past psychiatric symptomatology was also assessed. They found only one participant to have a psychiatric problem that preceded heavy drinking, suggesting that early problem drinking may have *contributed* to later psychiatric problems rather than occur as a secondary illness to psychiatric symptoms.

Early- Versus Late-Onset Drinkers

Many studies have identified two types of elderly alcoholics. The first, early-onset drinkers, are likely to be associated with long-standing behavioral problems. Schonfeld and Dupree[8] found early-onset drinkers to be intoxicated more frequently, have more severe emotional problems, and have experienced a higher frequency of severe withdrawal symptoms (ie, DTs, shakes, sweating). The second type, late-onset drinkers, are often characterized as "reactive drinking." It is frequently thought to be associated with stressors and social support changes such as retirement and bereavement. Schonfeld and Dupree[8] characterized this group as having less severe emotional problems and having stayed at their current residence for a significantly longer period of time, but were rated as having more severe alcohol problems (ie, less well-adjusted). The latter, however, may have been a spurious finding; that is, severity represented the only collateral scale (of eight) to reveal a significant group difference.

Other investigators have also identified significant differences between early- and late-onset alcoholics in terms of patterns of psychosocial functioning. For example, Finlayson and colleagues[9] found that stressful life events were associated with onset/exacerbation of alcoholism in over 80% of late-onset alcoholics (n=211), compared to only 45% of early-onset alcoholics.

Although the specific age that separates "early" from "late" onset varies from study to study, 55 to 60 years is usually regarded as an appropriate "cut-off." Thus, individuals who report that his or her problem drinking and associated difficulties/consequences began after the age of 55 would probably be considered late-onset drinkers. Estimates suggest that between one-third and one-half of elderly alcoholics are of the late-onset type.

The importance of distinguishing early- from late-onset drinkers may be most significant with regard to treatment issues. For example, in their review of the literature, Liberto et al[5] indicated that late-onset drinkers may be more psychologically stable and tend to stay in treatment longer than early-onset drinkers. Likewise, Mulford and Fitzgerald[10] found that late-onset alcoholics tended to drink smaller quantities compared to their early-onset peers, and were less advanced with regard to the alcoholic process. However, these researchers also point out that because their disease is less advanced, they may be less likely to receive treatment in the first place. Denial, the hallmark characteristic of alcoholism, is likely to be particularly strong among late-onset drinkers. Anecdotal evidence suggests that those who have "hit bottom" in terms of the disease process (ie, early-onset drinkers) are in a position to better understand, and perhaps benefit from, rehabilitation measures. However, whether or not onset type has any bearing on treatment success remains controversial.[11]

Gender and the Elderly Alcoholic

Over the years, a number of book chapters and research papers have been written dedicated to developing a better understanding of alcohol's

(as well as other drugs) effects on the health status of women. Many differences between male and female drinkers have been identified. Specifically, research indicates that in general, female alcoholics drink less and have shorter chronicity than their male counterparts. Even so, it is well-known that women show as much or more physical deterioration than men, suggesting that females are more vulnerable than males to the toxic effects of alcohol. *Recent Development in Alcoholism*, a series of publications produced by the American Society of Addiction Medicine and the Research Society on Alcoholism, devoted an entire volume (#12) to alcoholism in females.[12] The chapters within this volume continue to be some of the more frequently cited works in the area of alcohol consumption and women. For females, alcoholism is associated with specific vulnerabilities beyond the well-known physiological changes such as is seen in liver disease,[1,13] hormonal alterations,[14-16] and cognitive disruption.[17-18] Psychosocial changes are also evident and can be seen in terms of sexual dysfunction,[19] increases in alcohol-associated violence and victimization,[20] and mental health considerations.[13]

Despite the multitude of research that has addressed gender-specific consequences of alcohol consumption, relatively few studies have examined gender differences specific to the elderly alcoholic. Available cross-sectional and longitudinal studies have found that elderly women tend to have lower frequency of alcohol abuse, reduced consumption patterns, and lower prevalence of alcohol-related consequences than do elderly men (as reviewed by Liberto et al[5]).

Clinical characteristics of elderly Swedish first-time admissions were assessed for the years 1988 to 1992.[21] Individuals age 60 and older comprised 10% of the admitted patient population within one alcohol treatment facility offering both inpatient and outpatient programs (Department of Alcohol Diseases at Malmö General Hospital, Malmö, Sweden). Seventy-seven percent of the elderly admits were males (n=218) with females constituting the remaining 23% (n=64), reflecting a 1:3.4 ratio. The percentage of female admits increased over the previous five-year assessment period (1978-1982); prior evaluation data suggested that women comprised only 11% of elderly admissions (reflecting a 1:7.8 ratio). Demographic and alcohol use patterns and consequences were surprisingly similar between elderly males and females. No significant gender differences were detected with regard to marital status, referral source, type of treatment obtained, drinking patterns (eg, binge drinking, daily drinking, mixed), number of drinks typically consumed per drinking day, health problems (eg, alcohol-related, as well as non alcohol-related, physical and psychiatric health), meeting criteria for DSM-III-R diagnosis of dependence, and meeting criteria for ICD-9 diagnoses of dependence and/or abuse. The only significant difference observed was in onset of problem drinking: 41% of elderly females reported late-life onset compared to only 26% of elderly males ($p < 0.05$). There were no significant gender differences for early onset (40 years or younger) or for mid-life onset (41-59 years).

The lack of statistical difference for number of drinks consumed on a drinking day may seem surprising given data suggesting that males typically consume more alcohol than do females. A visual inspection of the data reveals that while men did consume a greater number of drinks than women, the differences were not statistically significant. These data suggest that while elderly male alcoholics continue to outnumber elderly female alcoholics, and while females appear to develop drinking problems later in life than do males, relatively few gender differences are evident (at least in this Swedish sample) among admitted patients.

Studies conducted on United States treatment populations have yielded comparable findings. Brennan and her colleagues[22] compared 55- to 65-year-old problem drinking men and women on drinking patterns, use of psychoactive medications, depression, help-seeking behavior, life-stressors, and social resources. Contrary to the Swedish findings, Brennan et al found alcoholic men to be significantly heavier drinkers (typical and largest amount consumed), and to have a significantly larger number of alcohol-related problems. As in the Swedish study, Brennan et al found that a significantly higher percentage of women classified themselves as late-onset drinkers.

Brennan and her colleagues[22] also found that elderly problem drinking women were significantly more likely to use psychoactive medications than were their male peers. Sixteen percent of women used antidepressants compared to 8% of men. Likewise, 20% of women used tranquilizers as compared to only 10% of men. These researchers conclude that special efforts may be necessary to identify and treat alcohol problems among aging females. Significant gender differences were also detected in the assessed psychosocial domains of help-seeking,

life stressors, and social resources. Specifically, women scored higher than men on depression indices, and were somewhat less likely than men to seek help for their drinking problems; however, this latter difference was not significant. Men and women also differed with regard to their areas of social support: more men reported support from a spouse, while more women reported support from children, extended family, and friends. These data may have important treatment implications; support system development, a critical feature of many recovery programs, may be a different process for male and female alcoholics.

In a review of several gender-difference studies of aging alcoholics, Gomberg[23] concludes that: 1) older problem drinking women are more likely than their male counterparts to be using psychoactive medications in addition to alcohol, and to be using them in greater quantities, 2) older women are more likely than older men to be widowed, 3) women are more likely to be late-onset drinkers, and 4) depressive disorder is more common among older female drinkers, relative to older males. These findings suggest that the pattern of demographic and psychosocial characteristics among elderly female alcoholics may be decidedly different than those present among elderly male alcoholics. This profile—elderly female widows with depressive symptomatology—may be at greater risk for development of a drinking problem and should be carefully evaluated, particularly if antidepressant or anti-anxiety medications appear to be indicated, and/or are already in use. It is critical to guard against the tendency to stereotype elderly female (or male) patients as teetotalers without need for assessment of substance use and/or abuse liability. Such "profiling" is dangerously counterproductive to patient care.

Consequences of Alcohol Consumption Among the Elderly

Elderly drinkers are vulnerable to a number of problems that may be either specific to them, or more deleterious to them, given the normal physiological changes that accompany the aging process. While it is beyond the scope of this paper to discuss all possible consequences of drinking, some of the more serious are summarized below. It is important to consider that although moderate levels of alcohol consumption have been, in some studies, touted as beneficial (for a review see Dufour, Archer and Gordis[24]), the dangers of recommending moderate drinking to the elderly patient may seriously outweigh any known benefit.

Rapid Onset and Longer Intoxication Periods

It is well known that normal aging is accompanied by a variety of physiological changes. For example, decreased body water and distribution, changes in absorption, metabolism and excretion, hormonal alteration, and cell loss have been documented.[7,25] Brain changes such as decreases in cellular brain mass and cerebral blood flow, increases in conduction time, and changes in the permeability of the blood-brain barrier are evident. These changes and others are responsible for heightened physiological vulnerability among the elderly drinkers to acute alcohol effects. Fatty tissue changes and altered metabolism result in more rapid and lengthier intoxications with less alcohol than might be found in younger cohorts.[26] These issues are probably responsible, at least to some degree, for the increased tendency to miss alcohol-related disorders in the elderly. For example, symptoms of intoxication may mimic symptoms of organic brain disease. In the elderly patient, the latter diagnosis may seem quite appropriate if alcohol consumption variables (ie, family intervention, alcohol odor) are not readily evident.

Injurious falls among the elderly are a significant health problem. Adams and Jones[27] report that falls are the most common accident among the elderly, accounting for approximately 40% of injuries. Furthermore, rates of injurious falls increase with advancing age, with falls being more common among women than men. The plausibility of alcohol consumption as an increased risk factor for falls among the elderly is obvious. Physiological evidence for such a relationship includes alcohol's propensity to affect balance and/or equilibrium (for a review of these studies see Adams and Jones[27]). Epidemiological evidence also suggests a link between alcohol and injuries in older people. For example, Adams and Jones reviewed several studies suggesting that a substantial percentage of elderly individuals presenting at emergency rooms for treatment of various injuries tested positive for recent alcohol consumption. Likewise, Mulinga[28] reported that of 125 elderly patients admitted to a UK hospital with a diagnosis of alcohol abuse or dependence, nearly 50% were admitted due to falls.

Despite evidence indicating the existence of a relationship between alcohol consumption and injuries, the data are not consistent with respect

to alcohol as a predictor of falls among the elderly. However, several methodological concerns are identifiable and may account for the lack of significant findings among several of the studies. Clearly, this is an area in need of further research.[27]

Alcohol and Drug Interactions

Many frequently prescribed medications interact with alcohol, including many that are commonly prescribed to the elderly. Recent estimates suggest that 60% to 80% of elderly individuals take some type of medication,[29] thus establishing that this problem is of considerable concern and warrants serious consideration. The Food and Drug Administration has indicated that as many as 50% of drugs taken by the elderly interact with alcohol.[25] Although alcohol/drug interactions have serious implications for any age group, they are particularly important in the elderly population due to aging-related pharmacodynamic and pharmacokinetic issues.

Frequently prescribed medications known to interact with alcohol include warfarin, hypoglycemics, sedative hypnotics, antidepressants, narcotics, antihypertensives, and anticonvulsants. For a complete review of the nature of these interactions, see the review by Adams[29] in the *Journal of the American Geriatric Society*. Pharmacokinetic interactions include alterations in absorption and metabolism (a more detailed discussion of the latter can be found in a later section). Pharmacodynamic interactions include enhancement of sedating effects (such as in the case of sedative hypnotics), increased bleeding time, and/or aggravation of gastric inflammation. Many of these effects can occur with relatively low alcohol levels.

Today, many medications once obtained only with a prescription are widely available over-the-counter, and the elderly are avid consumers of several of these. Drugs such as aspirin, acetaminophen, antacids, cimetidine, ranitidine, and non-steroidal anti-inflammatories are likely to interact with alcohol.[25,29]

Adams[29] studied the frequency of alcohol and concurrent medication usage among retirement community residents. She found that 47% of the participants reported using alcohol within the past six months. Fifteen percent identified themselves as at least weekly drinkers. Seventy-seven percent of the respondents used prescription medications. Alarmingly, 85% of those who consumed one to six drinks per week also used a "high-risk" medication. In addition, 80% of those who reported drinking seven or more drinks per week also used "high risk" medications. Considering all drinkers together (n=147), Adams identified the following use patterns: antihypertensives (50%), aspirin (27%), NSAIDS (20%), antacids or H_2 blockers (16%), cimetidine or ranitidine (10%), sedatives (11%), narcotics (5%), warfarin (5%), diabetes drugs (4%), antidepressants (3%), and gout medications (3%).

Obviously, the risk for dangerous alcohol/drug interactions increases with the number of medications used. Even infrequent or moderate drinkers are at risk for injury or other potentially serious consequences when alcohol is used in combination with certain medications. Secondary consequences must also be considered. For example, the simultaneous use of alcohol and narcotics is obviously dangerous due to compounded CNS depression—a serious, potentially life-threatening consequence. Secondarily and perhaps less obvious are the slowed reaction times and increased risk of falling resulting in a potentially serious injury. Even some antibiotics may adversely react with alcohol.[24] Other less obvious combinations include alcohol and decongestants, diuretics, antianginals, or laxatives.[30] Before prescribing a medication, it may be wise to consider that older patients frequently consult multiple physicians and may be taking prescription and/or OTC medications of which the treating physician is unaware.

As to prevention, specific patient education coupled with clear advice to abstain from drinking should be a top priority for those taking any medication that has the potential to interact with alcohol. However, this approach may only be effective for non-abusing, moderate consumers. Alcohol abusers may be in need of more direct intervention. Physicians' familiarity with community treatment options and patients' social support systems, as well as a host of other variables such as financial status and general health, is imperative to the facilitation of an appropriate treatment placement. Additional information concerning treatment of the elderly abuser is provided in a later section of this article.

Alcohol Effects on Liver in Elderly Drinkers

It is well known that heavy use of alcohol poses a serious health threat to all major organ systems. One of the most severely affected organs is the liver due to its role as the primary site of alcohol metabolism. A variety of mechanisms have been purported to play a role in the process of alcohol-induced liver damage including free

radical formation, impaired antioxidant defense, hypoxia, acetalydehyde accumulation, cytokine effects, and Kupffer cell activiation.[1] Some of these mechanisms may indirectly enhance or influence the production of collagen leading to liver scarring or even cirrhosis.

As reported in the *Ninth Special Report to the U.S. Congress on Alcohol and Health*,[1] age-specific death rates for alcohol-related cirrhosis dropped for all age groups except the elderly (1970-1992). Alarmingly, death rates increased 6.5% among individuals age 75 to 84 years, and 12.4% for those over 84 years of age.

While the basis for the observed increases in cirrhosis-related death rates among the elderly is not clear, older reports indicate that several physiologic changes occur within the liver. Some of the most frequently reported changes include liver shrinkage, decreases in hepatobiliary transport, and decreases in blood flow to the liver.[31] New reports, however, suggest that healthy elderly livers function as well as young livers.[32-33] However, it is possible that changes in alteration and/or function could leave the aging liver more vulnerable to alcohol-related diseases.

Another potential source of alcohol-related liver dysfunction concerns interactions between alcohol and medications (for a detailed discussion, see Adams' review in *The International Journal of Addictions* [34]). Such interactions frequently occur at the level of the liver and could potentially contribute to alcohol toxicity. The effects of alcohol on drug metabolism differ according to whether the patient is a frequent heavy drinker or an infrequent consumer. Thus, it is important to consider pharmacokinetic properties when assessing potential interaction effects. For example, acute administration of alcohol causes competitive control of the microsomal oxidizing system. Through this competitive interaction, the hepatic metabolism system is occupied with alcohol, leaving the drug to remain in circulation since metabolic processes are not available. This decreased clearance of various drugs may contribute to a potentially hazardous situation, particularly with drugs that cause sedation. Alternatively, in the chronic consumer, cytochrome P450 enzymes are induced. The induction of these hepatic microsomal drug-metabolizing enzymes results in more rapid breakdown of the drug, resulting in depleted levels. Drugs that are affected by this phenomenon include warfarin, some antihypertensives, and some antiseizure medications.

Alcoholism and Dementia

The relationship between alcohol use and dementia is complicated. It is well known that chronic alcohol consumption can result in cognitive deficits. However, generally speaking these deficits are mild to moderate in severity and are characterized by deficits on a variety of neuropsychological tests. The vast majority of chronic alcoholics (about 90%) thus constitute a group referred to as intermediate stage alcoholics.[35] These individuals do not meet the criteria for an alcoholic organic syndrome although many show some signs of cognitive impairment. Only a small proportion of alcoholics (the remaining 10%) develop an alcoholic organic mental disorder.[35]

Although both Korsakoff's syndrome and alcoholic dementia are characterized as clinically diagnosable syndromes, the existence of the latter is a topic of considerable debate.

Alcoholic dementia is characterized as a progressive dementing illness preceded by heavy alcohol consumption and persisting beyond the detoxification/withdrawal stage. Global, persisting, and disabling cognitive involvement are considered to be key features.[36]

Controversy as to the existence of the disorder stems from the lack of specific neuropathological criteria. Furthermore, Adams and Victor[37] have reported that the majority of the autopsy cases diagnosed as having alcoholic dementia were found to have brain leisons characteristic of those associated with Korsakoff's syndrome. Based on their findings from many years of extensive research, these investigators believe that alcoholic dementia is most likely another form of Korsakoff's syndrome, or constitutes an amalgamation of dementing disorders such as Korsakoff's syndrome, Alzheimer's disease, or hepatic encephalopathy.[38-39]

Proponents of alcoholic dementia as a separate clinical entity have recently established provisional guidelines for the refinement of DSM-IV criteria. Oslin and his colleagues[40] have proposed that Alcohol Related Dementia (ARD) is a syndrome with multiple etiologies such as alcohol neurotoxicity effects, vascular injury, or nutritional deficiencies. Under this proposal Korsakoff's syndrome would be seen as a disease manifesting as ARD.[40] Despite the controversial nature of alcoholic dementia as a separate clinical entity, it is clear that relatively high numbers of alcohol abusers have been found to be present among groups of demented elderly[41] (see reviews by Oslin et al[40] and by Smith and Atkinson[36]).

Detection of Alcohol Use and/or Abuse Among the Elderly

Screening instruments for detection of alcohol misuse disorders among the elderly are available, but discrepancies prevail regarding sensitivities and specificities of these instruments among aging adults. Two instruments that may be administered quickly and easily are the CAGE questionnaire[42] and the Michigan Alcoholism Screening Test–Geriatric version (MAST-G[43]).

The CAGE is a four-item test comprised of the following questions: 1) Have you ever felt you should cut down on your drinking? 2) Have people annoyed you by criticizing your drinking? 3) Have you ever felt bad or guilty about your drinking? 4) Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? The acronym CAGE is derived from one word in each item: Cut, Annoyed, Guilty, and Eye-Opener. The CAGE is generally administered orally. Two positive responses are indicative of a potential alcohol misuse problem. The MAST-G is a 24-item questionnaire generally administered via pencil and paper. It is derived from the original MAST to be of use specifically among geriatric populations. Both instruments are readily available for use in clinical practice or the hospital setting.

Although the CAGE has been widely used among the elderly, and the MAST-G was written specifically for elder administration, both have been scrutinized for their lack of sensitivity and potentially inappropriate use in this population.[44-45] A number of possible explanations have been offered for the low sensitivities of these instruments among older individuals, including smaller quantities of alcohol consumed, greater likelihood of hiding excessive drinking practices, less likelihood of having family/friend/job problems, and decreased probability of withdrawal symptomotology.[45]

Alcohol intake histories have been found to be effective at detecting excessive alcohol consumption. Naik et al[45] found that an alcohol history plus the addition of a specific question ("Do you drink spirits in your tea or coffee, or both?") were more sensitive than standardized instruments (Short-MAST and CAGE) in detecting excessive drinking, including an assessment of mean corpuscular volume (MCV). Likewise, Luttrell et al[44] found poor sensitivities for CAGE, MAST-G and MCV. They recommend the use of a simple, two-stage questionnaire. Stage one requires the patient to indicate whether or not he/she drinks alcohol in a typical week. A negative response indicates that an alcohol use problem is not likely, and stage two questioning is not conducted. However, should the patient answer affirmatively to the stage one question, stage two questions are asked. The four stage two questions (statistically derived from the MAST-G) are thought to be sensitive to the detection of a potential alcohol use disorder. It should, however, be noted that binge drinkers are likely to not advance to stage two questioning. This is a major limiting factor for the two-stage questionnaire. To the best of our knowledge, this instrument has not been validated.

There is a clear lack of consensus as to which of the above instruments or methods are the most sensitive to the detection of alcohol abuse among the elderly. However, it seems reasonable to assume that the use of one or more of these instruments is better than using nothing at all. For example, one might administer the CAGE and the two-stage questionnaire described above, in addition to a short drinking history inventory that clearly establishes both quantity and frequency of wine, beer, and spirits. An alternative approach might be to administer the MAST-G along with an alcohol history.

The addition of an alcohol history inventory is especially important in assessing potential alcohol/medication interactions in non-alcoholic, moderate drinkers. Clear, non-threatening questions need to address specific amounts of all types of alcohol consumed. "Buzz" terms such as "moderate" or "social" drinking should be avoided; patients that use these terms should be asked for clarification. These terms are not well-defined and are frequently used to describe a wide range of alcohol consumption patterns. Likewise, terms such as "never," "once in a while," and "only on special occasions" should be clarified. Furthermore, it is our experience that many individuals do not consider beer (and sometimes wine) to be an alcoholic beverage. Thus, questions directed toward the three specific types of alcohol (wine, beer, and spirits) are critical. Additional clarification (for example, defining "spirits") may be needed. The necessity of assessing the propensity for alcohol/medication interactions among the elderly (alcohol abusers as well as non-alcoholic users) cannot be over-emphasized.

Treatment Issues

The issue of whether or not the aging adult requires elder-specific treatment (ie, treatment programs designed specifically for the elderly)

to benefit from treatment efforts is unresolved. Most states do not have treatment centers set aside specifically for the elderly.[3] Relatively few studies have been conducted to determine whether or not elder-specific treatment is more effective than mixed-aged treatment. Among these, little evidence has been accumulated to suggest that outcome is less desirable for the elderly treated in mixed-age groups compared to elderly treated in age-specific facilities. About 50% of elderly individuals participating in mixed-age groups report abstinence one year later.[3] However, among the small number of studies that have compared the two treatment types, compliance and/or outcome have been shown to be favorable using age-specific approaches.[46]

The major advantage to elder-only treatment is the availability of therapy geared toward elder issues; a number of problems specific to the elderly such as social isolation, decreased income, poor health, and boredom have been identified. Disadvantages for elder-only treatment include cost and decreased contact with individuals from age groups representative of the outside world. In his review of the available literature, Atkinson[46] reports that the data support the idea that elderly individuals do well in mixed-age treatment. However, study design and methodology flaws leave open the possibility that mixed-aged treatment may not be the optimal strategy. His own work indicates that elderly people are frequently unhappy with common mixed-age occurrences, such as the use of profanity and stories depicting antisocial behavior and criminality associated with drug use.[46]

Special programs or groups within mixed-age treatment facilities may prove to offer the best of both worlds. Referring physicians should be familiar with existing facilities to direct elderly patients to appropriate facilities. For example, special groups for the elderly may not be beneficial if they are not directed or coordinated by a geriatric specialist. Likewise, a treatment facility that does not deal with Medicare and/or Medicaid may be of little use to the elderly patient.

The incentive to enter a treatment program may be elicited primarily from the physician's recommendation since family and job pressures to seek treatment are less likely to be present for the elderly patient. Consequently, assistance for the elderly alcoholic is likely to begin with keen physician discernment of the problem and proper referral. Likewise, aggravated illness due to unanticipated alcohol/medication interactions in the non-alcoholic elderly drinker is avoidable only with consistent physician involvement. We believe that detection, prevention, and treatment of alcohol misuse are key variables in the overall health care of our aging citizens. Clearly, the physician's role is critical in early detection of alcohol abuse/misuse and intervention to prevent further problems, and in preventing potentially fatal alcohol-drug interactions. An alcohol use history is vital. JOSMA

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The Benefits and Dangers of Alcohol

The saying that too much of a good thing can be bad for you is especially true in the case of alcohol. Drinking too much alcohol causes a wide range of serious health problems, including liver disease, certain types of cancers, heart disease, and alcoholism. However, research about alcohol has shown that moderate use can have some health benefits.

Moderate drinking is defined as one or two drinks per day for men and one drink per day for women and anyone over the age of 65. Women and the elderly have lower levels of body water, so smaller amounts of alcohol achieve higher blood alcohol concentrations than in younger men. One drink is usually defined as one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of 80-proof distilled spirits.

Adverse Health Effects of Alcohol:

- Heavy drinking increases your risk of certain disorders, such as liver cirrhosis (damage to liver cells) and pancreatitis (inflammation of the pancreas), and certain types of cancers, including cancer of the liver, mouth, throat, larynx (the voice box), and esophagus.
- Long-term health consequences of heavy drinking include loss of appetite, vitamin deficiencies, stomach ailments, digestive problems, skin problems, sexual impotence, obesity, heart and central nervous system damage, memory loss, and psychological disorders.
- Heavy drinking also increases risk of death from automobile crashes, injuries during recreation and work, higher likelihood of homicide and suicide, and harm to the fetus during pregnancy.



Abstain From Drinking If You:

- Are pregnant or considering pregnancy.
- Have a medical condition that can be worsened by drinking, such as an ulcer or liver disease.
- Have a personal or family history of alcoholism.
- Are taking medication that may interact with alcohol.
- Are planning to drive or engage in other activities that require you to be alert.
- Are under the legal drinking age.

Benefits of Alcohol:

- Moderate alcohol consumption (one or two drinks per day) may reduce your risk of coronary heart disease.
- Moderate alcohol consumption may also lower your risk of stroke.



What to Do If You Have (or Think You Have) a Problem with Alcohol:

- Discuss the problem with your doctor and ask what level of alcohol consumption is advisable for your situation.
- Get help by contacting your doctor or support groups if you cannot control the amount of alcohol you drink, or if your drinking is interfering with your ability to perform daily activities or other normal functions of life.

Alcohol Use in the United States
(from the National Center for Health Statistics report *Health, United States: 1998*)

Number of Alcohol-Induced Deaths in the United States, 1997
(not including motor vehicle fatalities): 19,576
Number of Deaths from Chronic Liver Disease and Cirrhosis (1997): 25,175
In 1997, chronic liver disease and cirrhosis was the 10th leading cause of death in the United States.
When asked, 51% of Americans ages 12 and over had drank alcohol in the past month (1996).
Of those, 15% are "binge drinkers," drinking five or more drinks on the same occasion at least once in the past month.
More men (67%) between the ages of 18 and 25 drink than women (54%).

Patient Handout #7

Do You Have a Drinking Problem?

Although many individuals with drinking problems may consider it a personal issue, the fact remains that alcohol abuse not only endangers the life and health of the problem drinker, it also affects family, friends, co-workers, and others with whom they come into contact.

Out-of-control drinking strains relationships, places a tremendous amount of stress on friends and family, and may even place your job in jeopardy if it interferes with your ability to work. Excessive amounts of alcohol can cause damage to your liver and brain, as well as other dangerous health problems.

The good news is that there is hope for those who recognize that they have a problem and seek help. If you think you or someone you love has a drinking problem, see your doctor about available treatment options.

Types of Alcohol Problems:

- Alcohol Abuse: A pattern of drinking that is accompanied by one or more of the following situations within a 12-month period: 1.) failure to fulfill major work, school, or home responsibilities; 2.) drinking in situations that are physically dangerous, such as while driving a car or operating machinery; 3.) recurring alcohol-related legal problems, such as being arrested for driving under the influence of alcohol or for physically hurting someone while drunk; or 4.) continued drinking despite having ongoing relationship problems that are caused or worsened by the effects of alcohol.
- Alcoholism: A pattern of drinking that includes: 1.) a strong craving for alcohol; 2.) loss of control and inability to stop drinking once begun; 3.) suffering from withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety after a period of heavy drinking; and 4.) needing increasing amounts of alcohol in order to feel "high."



Alcoholism Treatment:

There is no complete cure for alcoholism, but it can be treated. The type of treatment depends on the severity of the problem and the resources that are available in your area. Treatment may include:

- Acute withdrawal and detoxification, which is the medical process of safely getting alcohol out of your system.
- Prescription medication, which can help prevent relapse to drinking once you have stopped.
- Individual or group counseling, which may include families and partners who oftentimes also need help to cope with the stress of dealing with a family member with alcohol problems.

Where to Get Help:

- Talk to your doctor.
- Seek out self-help organizations: Alcoholics Anonymous, Al-Anon, Family Groups, Inc., and Alateen are a few examples of organizations designed to help individuals struggling with alcohol issues.

Sources:

Journal of the American Medical Association, January 6, 1999, Volume 281, p. 104. Copyrighted 1999, American Medical Association. Reprinted with permission.

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Patient Handout #7

Medschool.com: Opportunity or Threat?

Chris Candler, MD

During the past several articles I explored the role of technology in medical practice. In this article I explore the divisive nature of educational technology and its role in medical education.

In 1999 the Association of American Medical Colleges (AAMC) initiated a forward-looking Delphi study to explore future uses of the Internet and information technology at academic medical centers.[1] During the first phase of this study more than 700 individuals were asked to generate predictive statements regarding the effect of technology on academic medicine in the year 2010. Deans, hospital CEOs, informaticists, librarians, and distinguished educators each contemplated on the possible effects that technology might have in their area. This resulted in more than 75 predictions, which were then normalized, edited, and compiled into 75 futuristic statements. The same respondents were then invited to rate the desirability and likelihood of these futures.

The results of this important study may be surprising to some. Several of the more highly rated statements foretell advanced uses of technology in health professions schools, such as customizable online curricula, virtual patients, and digital simulators for procedures. Others predict the standardization of curricula, a decrease in the number of medical school faculty, and the formation of educational consortia. And while not rated highly, one startling statement claimed that students would complete the first two years of medical school via the Internet. Seemingly in response, other statements acknowledged the indispensable merits of live instruction and offered a more balanced approach. Still, these predictions make one wonder: When does technology go too far?

While these prognostications may sound like visions of a distant and unviable future, a new company has plans to harness the potential of the Internet to deliver healthcare education in unprecedented ways. Medschool.com, based in Santa Monica, California, plans to address the lifelong learning needs of healthcare knowledge organizations and workers through an integrated Web site hosting online lectures, review books, discussion boards, question banks, website reviews, and a medical bookstore.[2] Online forums allow students from around the world to discuss strategies to select a residency, the anxieties surrounding board exams, and the stress of third-year clerkships. Needless to say, this web site has become a popular educational resource for student across the globe.

But does educational technology work? The answer is an emphatic "probably." While there are precious few studies examining web-based instruction, the evidence base for the more generic computer-aided instruction, while varied, is replete with studies that illustrate the favorable effect of technology.[3,4] However, several notable educational technology initiatives have been met with disastrous results when computers were carelessly placed in the classroom with little regard to purpose or need.[5] Not surprisingly, other studies have found the teacher-student interaction to be an irreplaceable component of some educational environments.[6] Perhaps the most important question is: What is the optimal role of technology in the medical education environment?

Like many physicians, educators often worry that technology may one day make them obsolete. The fear and threat of technology have caused more than one instructor to wonder if the computer on their desk will one day replace them. Fortunately, there is no evidence that this

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will be the case. The world's fastest processors and most sophisticated applications cannot replicate the subtleties of an empathic clinician or reproduce the captivating lecture. Moreover, computers cannot provide medical students the essential sociocultural education that introduces them to the language, behaviors, and relationships of the profession.

So what is the role of technology in modern medical education? In a word: complementary. Many of the exciting advances in educational technology now offer students new learning opportunities that do not compete with faculty lectures or patient exposure. Faculty, along with technology specialists, have found ways to develop both independent and group-based learning tools that enrich the educational process. Through this new technology medical students can visualize the complexities of the digestive physiology through interactive animations, review high-quality neuroanatomy slides at home the night before an exam, and practice a thoracentesis on a simulator before ever cutting on a patient. All of this without canceling a single lecture hour or discarding a single book. Clearly, instructors and students can benefit from both the new and the traditional.

But the fear and threat of technology will likely remain. In 1811, during the formative stages of the industrial revolution, a group of agrarians led a violent revolt against textile factories near Nottingham, England. Under the name of Ned Ludd these insurgents destroyed mechanized looms, fearing that technology and machines would diminish the need for human laborers and forever despoil their culture. But the Industrial Revolution was too big and government forces eventually quelled the rebellion. Though the Luddite rebellion had little impact on industrial progress, anti-technology attitudes and resistance to change are alive and well today. Somewhere between the centuries-old cynicism and the Pollyannish delusions of today's high-tech economy we will discover a way to partner with the technology we have developed and effectively bring it to the classroom.

The Author

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2000 Annual Meeting Proceedings

REPORT OF THE PRESIDENT

Opening Session, OSMA House of Delegates

By Boyd O. Whitlock, MD



Mr. Speaker, Officers, Trustees, Delegates, and Guests: I would like to welcome you to the 2000 Annual Meeting of your State Medical Association.

This is my final report to you as President of the OSMA. I have greatly enjoyed serving in this capacity. I want to thank all the council and committee chairmen, the Executive Committee, the Board of Trustees, and especially Mr. Foy and all of his staff for their support. All their efforts have made my job an easy and pleasant experience. We can all be comfortable in knowing that we have worked hard and done our best to make the OSMA a better organization. First of all, I would like to thank the Alliance for their help. They have been very helpful in putting members on all our major councils and committees. We truly do consider them a partner in all of our efforts.

The Long Range Planning Committee sets the plans and goals of our Association and meets at least every six months to update the plan. At the closing session of this House at last year's Annual Meeting, I told you that my primary aim this year will be to carry out this plan, as set by the Planning Committee. This plan and these goals have been our yardstick by which we set our programs and activities. All that your Association has done this year has been with the basic idea of being more proactive in carrying out this long-range plan. We have been successful in most areas.

Thanks to Dr. Brandt and the staff, our legislative efforts have been more productive than ever these past two years. It is remarkable how successful they have been in promoting the good bills related to the practice of medicine and seeing that all the bad bills—and these are many!—get defeated. We owe much to Dr. Brandt, OSMA staff members Kathy and Lydia, and to our new lobbyist, Dan Draper. I especially want to thank our chief lobbyist, Lynne White, for all her efforts and for helping to make OSMA a respected association at the Capitol. We have also kept up good communication with the AMA and our legislators in Washington through the efforts of Dr. Boatsman and his committee and our Washington lobbyist, John Montgomery. You will be hearing from them at the OMPAC legislative luncheon on Saturday. Only one negative comment in the legislative area – our support of OMPAC is not good. Only 9% of our active members contribute to OMPAC.

The Physicians' Campaign for a Healthier Oklahoma is an ongoing effort to improve the state of the health of all our patients. We have visited many county medical societies to talk with doctors about the Campaign and other Association activities. We have invited representatives from the health department in each county to attend those meetings. Through these county visits and a recent meeting at the OSMA with county presidents from around the state, we have improved communications with our rural physicians. We have become accredited to offer CME. Our Internet activities and our Web site are much improved and will greatly improve our communications with members in the years ahead. To improve physicians' advocacy, we have met regularly with Medicare representatives, the Health Care Authority, and HMO medical directors to help physicians and patients in these areas. We have brought the *Journal* publication back in house, and our new Editor-in-Chief and his staff continue to make the OMSA *Journal* a prize effort. Our PLICO Health and Malpractice programs, our credentialing service, and our Physician Recovery Program continue to do well.

We realize the importance of involving the students, residents, and physicians new in practice and have met with them to assure that they will become members and stay active. Over 130 of the 160 first-year students are new members of OSMA/AMA. You will be hearing more soon about financial assistance for students and residents through a revitalized Education and Research Foundation. Over 400 residents in the state are OSMA/AMA members. We are reestablishing a Resident Council. Tomorrow there will be a Young Physicians' meeting to hear what these physicians new in practice would like to hear from organized medicine and to begin to establish a statewide Young Physicians' Group. The new Communication Council and the new Building Committee are working to improve our teleconferencing sound systems and find ways to add videoconferencing in the future so that physicians around the state can participate in OSMA activities from their own hospitals and offices. These are but a few examples of our attempts to make the OSMA a more proactive organization.

The areas of finance and budgeting have certainly been challenging. Dr. Beller will discuss this later this morning. We have added a few new experienced staff to help add to and improve our programs. To meet our goals, we have added a new lobbyist. We have certainly had increased utilization of our legal council in areas

of legislation and physicians' advocacy. We have established the Physicians' Campaign for a Healthier Oklahoma as a benefit to physicians and especially the public. Your Medical Association is trying to be proactive. Your OSMA is trying to be the kind of association you can be proud of…an association of which you will want to be a part. We will make mistakes…if we did not, it would probably be because we were not trying to change to cope with changing world.

As we finish this year, I feel comfortable that we continue to make progress. There are, however, a few areas of concern. As I have discussed in my *Journal* articles and Board reports, these are changing times in the practice of medicine. We need to position ourselves to make the appropriate changes to best meet the evolving need of our members. We may need to change our structure. We need to look at our House of Delegates and our Board of Trustees. We need to look at the way our state and county societies work together. We need to look at shared responsibilities, etc. to help facilitate this process. I am appointing a Task Force on Governance that will study and make recommendations to the Long Range Committee and the Board regarding changes we might consider to make our Association more responsive to the needs of our members.

Another area of concern is in the area of internal communications. One of my goals at the beginning of the year was to improve the day-to-day working relationship between OSMA and the counties. In my report to you one year ago, I pointed out that our goal #5 discusses increasing unity and congeniality within the profession and goal #7 has to do with communicating effectively. I am disappointed that we have not made much progress here. We have made trips to many of the county societies and recently had an excellent meeting with the county presidents…all efforts to improve relationships with counties and to make them more a part of our Association. OSMA and our two largest counties must work together if we are to maintain a strong Association. We must share ideas. We must be willing to sit down together to set goals to discuss mutual problems and to make decisions which will benefit all of us. I think this will be essential to our success in the coming year. We cannot function well as three or four separate groups. We must do what we do…together.

In closing, I thank all of you for your support and hard work during the 1999-2000 year. I know you will continue this as Dr. Robert Weedn begins his year as President. Your organization (OSMA), its staff, and Brian Foy need your support. Your voice should be heard at your county, state, and national levels. You can make a difference. We need a collective voice from all who practice medicine. We are all in this profession together.

When it is time to plan the future of medicine, please consider carefully and make the right choice…to continue to be a member at all levels of our Association. Thank you.

Boyd O. Whitlock, MD
OSMA President, 1999-2000

Annual Meeting Scrapbook...









REPORT OF THE PRESIDENT

Closing Session, OSMA House of Delegates

By Robert J. Weedn, MD



Good morning Mr. Speaker, fellow physicians, and delegates:

Thank you again for the honor and privilege of serving and representing you and our profession as we advocate for our patients first and foremost, and in so doing, create advocacy for our profession. If we take care of our patients with our hearts, we not only will swell our own hearts but our patients will reciprocate many-fold.

We have a common bond of education, experience, and commitment. We entered this profession with noble aspirations to help and care for our fellow man. As the Oath of Hippocrates, which we all have taken, states, we must always put our patients first and foremost, but we also commit to take care of our fellow physicians. It is my pledge to you that I will follow these guiding principles as I lead this organization. I cannot do this successfully without your input, love, and support.

Your OSMA is not doing the same old things in the same old way—and hasn't been for the last few years—as our mission statement and goals have been refined and defined in an evolving, long-range planning process. That long-range plan has been endorsed and approved by you, the House of Delegates, representing our membership on a yearly basis. Your OSMA has become proactive instead of reactive. We have surveyed the membership and will continue to do so periodically, taking the wishes and desires of our membership and incorporating them into the Long Range Plan as modified annually. Furthermore, it is our goal to complement, and not compete with, any of our component societies. We must be mutually supportive and I promise you that I will do everything in my power to uphold that goal. To do that we must have enhanced dialogue and communication in a simple, clear, and useful manner. We must work through any differences that we may have with mutual love and respect. With this understanding and a cooperative effort, we will be stronger than we could ever be alone. Your leadership is already aware of my commitment, but I wanted to make this pledge to you personally.

I will be communicating with each of our county medical society presidents in the next few weeks to obtain input and ideas about how we can accomplish these goals together and, in particular, how to make sure you and your county medical society and its membership can best be represented in OSMA councils and committees. It seems that, quite frequently, physicians who basically work as individuals to care for their patients have a difficult time working together for our profession if there is no external threat. It seems to me that the major threat to our successes in representing you at this point in time is internal dissention and divisiveness. We must change the tone of the rhetoric. It will be my personal goal to overcome and to represent our patients and all of our members in a positive manner and with integrity. Thank you. I will look forward to your input and support. We need your active involvement and that of all our members...and we must recruit new members. Our guiding principle will be: Is it good medicine, and is it good for our patients? Is it good for you and your medical society, the OSMA, and the AMA? And is it good for the House of Medicine?

Robert J. Weedn, MD
OSMA President, 2000-2001

REPORT OF THE EXECUTIVE DIRECTOR

Opening Session, OSMA House of Delegates

By Brian O. Foy



Mr. Speaker, Dr. Whitlock, Dr. Weedn, Officers, Trustees, Delegates, Alliance Members and Guests:

For just a moment, I'd like for you to picture yourselves as ship owners. Several years ago, you—as ship owners—ordered your flagship vessel—the OSMA—into port. The ship had been through a long, turbulent voyage and had faced many storms and rough seas.

When the ship reached port, many long-time crew members departed—including the ship's Captain and several of his officers and crew. You then took stock of your ship. She was in surprisingly good shape, despite all the rough weather. She was financially and structurally sound. Her remaining crew were hardworking and dedicated, wondering where the next voyage would take them. *Where were you going?*

You then resurrected your Long Range Planning Council and took a long, hard look at the ship's future. The mission statement and goals were revised. It was time to take the ship in a new direction. *But where were you going?*

You appointed an interim Captain who very ably managed the remaining crew members. You, the shipowners, stepped in and helped the crew steer the ship through some very important events: the passage of landmark legislation which "reined in" the HMOs and the successful legal challenge to optometrists performing laser surgery. Who would have predicted then that great legal victory would soon be thrown out the window by a reactionary legislature?

It was also during this time that you made a decision to hire a new Captain and to set a bold new course for the ship. After a thorough search across the country, you selected me to be your next Commanding Officer. I reported aboard the OSMA in January of 1998 and began to take stock of the ship. It was structurally sound, and it was in excellent financial condition with sound reserves. The crew, while still a bit squeamish from previous voyages, was motivated and capable although somewhat sparse. You handed me your long-range plan—your vision, the territories you wanted to explore—and asked me to prepare the navigation charts to get us there. I went up to the bridge, broke out the charts, reached for the compass, and began studying various routes to prepare the ship for its next voyage.

We set sail in mid-January of 1998 and immediately ran into bad weather. In fact, as we look back on those days, it may have been a hurricane! The optometry/laser surgery issue had re-emerged in the legislature and to quote our chief lobbyist Lynne White, "it had serious legs." We battened down the hatches and prepared for the worst. We fought the good fight—all of us—but we were unsuccessful. A bitter defeat? Of course. But we learned our lesson. If you're going to engage in a battle, you need bigger guns—and more of them.

We went below decks and licked our wounds. You ordered the ship back into port for damage assessment. There were a few battle scars but no permanent damage. It was time to get serious. We needed more ammunition and the expert gunners to load it and to know where to fire.

Using the long-range plan as our official "battle plan," I began the process of finding additional crew members with the necessary "ammunition" of training and experience. I'm happy to report that that mission has been accomplished. The ship is "manned and ready."

In the past two and a half years, your ship—the OSMA—has gotten stronger. We have traveled a respectable distance, but there is so much territory left to cover. I won't take up your time today to review everything we've accomplished or plan to accomplish. That information is presented fully in your Delegates' Handbooks and in the special brochure in the back of the room entitled "OSMA: Working on Your Behalf." Please take a few moments to look over those materials and to consider what your state Association is doing for you.

It has been a privilege serving as your Captain these past two plus years. Your ship is in excellent condition. The crew is well-trained and ready to go. We have the wind at our backs right now, and there are "oceans of opportunity" before us. But the Association members—the shipowners—must decide our next destination. Tell me where you want to go from here, and I'll be sure the ship gets there—safely, efficiently, and expeditiously.

Thank you.

Brian O. Foy
OSMA Executive Director

OPENING SESSION, OSMA House of Delegates

Friday, May 5, 2000

I. Call to Order, Invocation, and National Anthem
The House of Delegates convened the 94th Annual Session of the House of Delegates at The Westin hotel in Oklahoma City on Friday, May 5, 2000. Bruce L. Storms, MD, Speaker, House of Delegates called the meeting to order at 8:45 a.m.

Delegates stood for the Pledge of Allegiance led by David Russell, MD.

The National Anthem was played by David Hooten, trumpet soloist originally from Duncan, who resides in Oklahoma City.

The invocation was given by Representative Jeri Askins.

II. Report of the Credentials Committee
Credentials Committee Chair Andrew Gin, MD, announced that a quorum was present.

III. Necrology Report
Dr. Bozalis asked the Delegates to stand as he read the names from the necrology report. After reading the names, David Hooten, trumpet soloist, played Amazing Grace.

IV. Introductions
Dr. Storms introduced those at the head table: John R. Bozalis, MD, Vice-Speaker of the House of Delegates; Boyd O. Whitlock, MD, President; Robert J. Weedn MD, President-Elect; Mary Anne McCaffree, MD, Immediate Past President; Gary Strebel, MD, Vice-President; David Russell, MD, Chairman, Board of Trustees; Jack J. Beller, MD, Secretary-Treasurer; Brian O. Foy, Executive Director; Cheryl Baker, OSMA Alliance President; Mary Ann Couch, OSMA Alliance President-Elect; Timothy Flaherty, MD, Vice-Chairman, AMA Board of Trustees.

Dr. Storms then introduced and welcomed the following special guests: OSMA Past Presidents Ed Calhoon, MD, Joe Crosthwait, MD, Billy Dotter, MD, Norman Dunitz, MD, James Funnell, MD, Jay Gregory, MD, David Harper, MD, Floyd Miller, MD, Mary Anne McCaffree, MD, and David Selby, MD; Wilford Watkins, AMPAC Representative; Betty Haisten, Southern Medical Association Alliance President-Elect; Susan Paddack, AMA Alliance President-Elect; Mike Wild, AMA Federation Relations (Field Representative); Carrie O'Malley, AMA Regional Director (AMA Washington Office); John Montgomery, OSMA Federal Lobbyist; Lynn White, OSMA State Lobbyist; John Balbas, Lara Whittington, Jeff Sparling, Chris Renshaw, and Mark Paden, Medical Student Section; Doris Clark, Jana Timberlake, and Debbie Adams, Oklahoma County Medical Society; Paul Patton and Tanya Luce, Tulsa County Medical Society; Michelle Seba, OCVO; and Linda Scoggins, OSMA Legal Counsel.

Dr. Storms announced that reference committee reports, late resolutions, and various other reports were located at the back of the room.

Dr. Storms explained the candidates' forum to be held after the Opening Session House of Delegates recess.

Dr. Storms announced the times of various meetings taking place during the weekend and also invited members to the OSMA/OSMAA luncheon to be held directly following the Opening Session of the House of Delegates meeting, as well as the OU Medical Alumni Dinner and the Presidential Inaugural.

V. Approval of the Minutes of the 1999 Annual Meeting
Motion was made, seconded, and passed to approve the 1999 Opening and Closing Session Minutes.

VI. AMA-ERF (Presentation of Checks)
Dr. Storms introduced Mrs. Cheryl Baker, President of the Oklahoma State Medical Association Alliance. Mrs. Baker thanked the OSMA for their support and gave a few brief remarks regarding the OSMAA. Mrs. Baker introduced Susan Paddack, American Medical Association Alliance President-Elect, who then made brief remarks regarding the AMA and the OSMA fundraising efforts, education, and community service. Mrs. Baker then introduced her guests, Mrs. Mary Ann Couch, OSMA Alliance President-Elect; Betty Haisten, Southern Medical Association Alliance President-Elect; Sandy Breipohl, AMA Foundation Chair. Ms. Breipohl presented the Foundation checks to Dr. Jerry Vannatta, who accepted the checks for the OU College of Medicine, Oklahoma City campus, and OU College of Medicine, Tulsa campus.

VII. Presentation of Awards
***Journal* Awards**
Dr. Storms introduced Michael Pontious, MD, *Journal* Editor-in-Chief, to make the presentations of the *Journal* Awards.

Dr. Pontious presented the Charlotte S. Lecbron Memorial Trust Fund Award to Laurence H. Altshuler, MD, Oklahoma City, for his article entitled: "Alternative Medicine: What is the Physician's Role?" published in the May 1999 issue.

Sandeep N. Shah, MD, Oklahoma City was presented with the Mark R. Johnson Excellence in Medical Writing award, "Coronary Artery Disease in Women: A Silent Killer" (Dr. Shah was unable to attend).

Dr. Pontious presented the Best *Journal* Cover Photograph Award to Euan M. McMillan, MD, Oklahoma City, whose photograph of a white egret appeared on the cover of the September 1999 issue.

Wyeth-Ayerst Physician Award for Community Service
Dr. Bozalis introduced Dr. David Russell to present the Wyeth-Ayerst award to Dr. Gordon H. Deckert. The award was presented on behalf of his efforts with the Physicians' Campaign for a Healthier Oklahoma.

Don J. Blair Friend of Medicine Award
Dr. David Russell presented the Don J. Blair Friend of Medicine award to Drew Edmondson for his outstanding work on the Tobacco Coalition.

Take Care Campaign Presentations
Dr. Bozalis introduced Dr. Gary Strebel who presented Angela Buckalew, KWTV-Channel 9 (Oklahoma City) and Keith Jones, KOTV-Channel 6 (Tulsa) a plaque in appreciation for their sponsoring the Take Care Campaign.

VIII. Remarks from the AMA Speaker, Timothy Flaherty, MD
Boyd O. Whitlock, MD, OSMA President, introduced the AMA Speaker, Timothy Flaherty, MD, Vice-Chairman, American Medical Association Board of Trustees.

Timothy Flaherty, MD, Vice Chairman, AMA Board of Trustees expressed the great loss of Perry Lambird, MD. Dr. Flaherty thanked the officers and members of the Association and made remarks concerning health care and public sector advocacy. Dr. Flaherty emphasized one voice with physician partners.

IX. Remarks from the President
Boyd O. Whitlock, MD, was called to the podium to make his outgoing address.

Dr. Whitlock thanked Council/Committee Chairs, OSMA Alliance, and OSMA staff for their hard work. Dr. Whitlock stressed internal communication

with the Oklahoma County Medical Society (OCMS), Tulsa County Medical Society (TCMS), and the rural county medical societies. He informed the House of his plans to appoint a Governance Task Force to make the Association more responsive to the needs of the members. Dr. Whitlock closed by thanking everyone for their support and asked that they continue that support for Dr. Weedn, the incoming OSMA President.

X. Remarks from Jay A. Gregory, MD, President, Oklahoma Board of Health
Dr. Storms introduced Dr. Gregory and asked him to give a report on the ongoing investigation of the Nursing Home Division of the Oklahoma State Department of Health.

XI. Recess for Delegations Caucus
Dr. Bozalis declared a 10-minute recess for county medical society caucuses to prepare for nominations of the various association offices. Nominations would be made from the floor and seconding speeches would not be made. A reminder was made that one Delegate needed to be ready to make nominations from the floor for the various offices.

XII. Nominations for Election
Dr. John Bozalis, Vice-Speaker of the House, announced the floor was open for nominations for the following positions:

President-Elect
Gary F. Strebel, MD, Oklahoma City

Vice-President
W.F. Phelps, MD, Tulsa

Speaker, House of Delegates
Bruce L. Storms, MD, Chickasha

Vice-Speaker, House of Delegates
David S. Russell, MD, Enid

Trustees
District II: Kay, Noble, Osage, Pawnee & Payne Counties
Trustee: Richard Keim, MD
Alternate: Woody Jenkins, MD

District III: Garfield, Grant, Kingfisher, Major, Alfalfa, Woods & Logan Counties
Trustee: Sanku Rao, MD
Alternate: Phil Self, MD

District IV: Beaver, Cimarron, Dewey, Ellis, Harper, Major, Texas and Woodward Counties
Trustee: Ed Calhoon, MD
Alternate: Jan Chleborad, MD

District V: Beckham, Blaine, Canadian, Custer, & Roger Mills Counties
Trustee: Mike Talley, MD
Alternate: Curtis Schenk, MD

District IX: McIntosh, Muskogee, Okmulgee, Sequoyah, & Wagoner Counties
Trustee: E.P. Couch, MD
Alternate: Joel Anderson, MD

District XIII: Caddo, Comanche, Cotton, Tillman, Grady, Jefferson & Stephens Counties
Trustee: Randall Jenkins, MD
Alternate Trustee: Kent King, MD

District XIV: Greer, Harmon, Jackson, Kiowa, & Washita Counties
Trustee: no nominations were made
Alternate: no nominations were made

AMA Delegation
Delegates:
Jack J. Beller, MD, Norman
Jay A. Gregory, MD, Muskogee
Bruce L. Storms, MD, Chickasha
W.F. Phelps, MD, Tulsa

Alternate Delegates:
Susan A. Husain, MD, Tulsa
Varsha R. Sikka, MD, Tulsa
Jennifer Trottman, MD, Tulsa
Kautilya Mehta, MD, Oklahoma City
Mayo Gilson, MD, Oklahoma City
William Bernhardt, MD, Oklahoma City

PLICO Board of Directors
William Coleman, MD, Oklahoma City
Scott Dunitz, MD, Tulsa
David Harper, MD, Tulsa
Michael Haugh, MD, Tulsa
David Selby, MD, Enid

OCVO Board of Managers
Varsha Sikka, MD, Tulsa
Noble Ballard, MD, Altus
Jan Chleborad, MD, Woodward

XIII. Remarks of the Chairman of the Board of Trustees
Dr. Storms called Dr. Whitlock to the podium to recognize Dr. Russell, Chairman of the Board of Trustees. Dr. Whitlock thanked him for all of his dedication and hard work and presented him with a watch from the officers and House of Delegates. He thanked Dr. Russell for serving as Chair of the Board of Trustees for the past two years.

Dr. Russell referred to the Report of the Board of Trustees in the handbook and the Supplemental Report available as a handout. Dr. Russell highlighted the following items in his report:

- Dr. Russell informed the House of the newly elected Chairman of the Board, Mark C. Johnson, MD, and Vice-Chair, Board of Trustees, David Nierenberg, MD.
- Dr. Russell stressed advocacy for the physicians and patients of Oklahoma.

Dr. Russell stated that it has been an honor serving as Chair of the Board of Trustees. Dr. Russell expressed his appreciation to the Board of Trustees for their dedication, participation, and stability with issues that came before the Board. He concluded by thanking Mr. Foy and the OSMA staff for their hard work and dedication.

XIV. Remarks from the Secretary-Treasurer
Jack J. Beller, MD, provided the House of Delegates with an outline summary of the Secretary-Treasurer's Report. Dr. Beller briefly reviewed the following:

I. The annual audit of Ernst & Young found no problems with the finances of the Association.
II. 1999 year-end audited financial statements reflected that OSMA finished the year with $59,514 net revenue over expenses.
III. The first quarter 2000 financial statements indicated that the Association was $105,188 revenue over expenses.
IV. A change in the investment policy for OSMA was implemented in November 1999.
V. The 2000 OSMA annual budget proposal.
VI. The financial requirements for provision of wanted and needed services to the members of the Association:
 1. Use of $153,859 from Accumulated Retained Earnings for the year 2000.
 2. Inflation adjustment for the OSMA annual dues set at $400 per year.

Dr. Beller stated that the Association could make a choice to move forward and provide members with services that are needed or to decide to move backwards. He also encouraged the House to support the proposed budget for 2001 and the proposed dues increase.

Dr. Beller concluded his report by stating that he would be available for any questions or concerns the House may have.

XV. Report of the Constitution and Bylaws Chairman
Dr. Storms updated the House on various changes and recommendations being proposed by the Bylaws Committee. Dr. Storms stated that changes of the first reading were referred to Reference Committee I. Second-reading bylaws changes were read for first

reading last year and are located under Tab I. Dr. Storms stated that there were four areas to be voted on and they were not debatable. The following grammatical changes would be brought to the Speaker's attention:

1. Medical Student Section Representation of the House.
2. Medical Student Representation of the OSMA Board of Trustees.
3. Trustee Re-apportionment.
4. Planning & Development Council Chair change.

XVI. Report of the Executive Director
Mr. Brian O. Foy addressed the House and spoke about the challenges and accomplishments of the past year. In closing, Mr. Foy assured the House that he was ready and able to take on the challenges of the upcoming year. He informed the House of a special brochure that was available entitled, "OSMA – Working on Your Behalf," and encouraged the House to review the information presented in the brochure.

XVII. Presentation of Business to Come Before the House
Dr. Storms announced the times of the reference committees and announced the late resolutions that were to be presented, which included Late Resolution 11 in Reference Committee II and Late Resolution 12 in Reference Committee III. Dr. Storms announced that the reference committee reports would be available at the OSMA registration on Saturday, after 4 p.m. He also reminded the Delegates that voting would be from 7:30 a.m. until 8:30 a.m. on Sunday and all Delegates would need to be credentialed in order to vote.

XVIII. Other Business
Dr. Storms stated that the Closing Session would begin promptly on Sunday at 8:30 a.m. Dr. Storms read the list of sponsors and informed the House that Gerald Zeavin, MD, was the recipient of the early registrant gift. He read the list of exhibitors and encouraged the Delegation to visit the booths.

XIX. Recess
There being no further business to come before the House, a motion was made, seconded, and passed to recess for the reference committee meetings and the candidates' forum. The House would reconvene on Sunday, 8:30 a.m. on May 7, 2000.

CLOSING SESSION, OSMA House of Delegates

Sunday, May 7, 2000

I. Call to Order
The Closing Session of the 94th Annual Meeting of the House of Delegates was called to order by Bruce L. Storms, MD, Speaker, House of Delegates, at 8:30 a.m. at The Westin hotel in Oklahoma City.

II. Invocation
Mrs. Cheryl Baker, outgoing OSMA Alliance President, gave the invocation.

III. Report of the Credentials Committee
Credentials Committee Chairman Andrew Gin, MD, announced that a quorum was present.

IV. Announcements
Dr. Storms announced that reference committee reports and late resolutions are on a table in back of the House of Delegates. Dr. Storms announced the AMA Foundation silent auction winners and informed the Delegates that amendments to the reference committee reports need to be in writing with the original taken to the Tellers desk who will forward to staff. Amendments will not be accepted verbally on the floor, only in writing. Dr. Storms discussed the order of business of the House, stating that Reference Committee III will be the first order of business followed by Reference Committee II and ending with Reference Committee I. Dr. Storms also stated that written ballots will be taken on the deunification issue.

V. Remarks of Jay A. Gregory, MD
Dr. Storms introduced Jay A. Gregory, MD, to present the Perry A. Lambird, MD, Memorial Resolution to the Lambird family. Dr. Gregory introduced Dr. Lambird's brother- and sister in-law, Chris and Margaret Salyer, and daughter and son-in-law Susannah and Jack Collier.

Dr. Gregory recognized Dr. Lambird for his work for organized medicine and stated that he will be greatly missed by all members of the OSMA. The Lambird family received a standing ovation from the Delegates.

VI. Remarks of the Incoming President
Dr. Storms introduced Robert J. Weedn, MD, to make remarks before the House. Dr. Weedn thanked the Delegates for the honor and privilege of serving and representing them in their profession as they advocate for their patients first and foremost, and in so doing create advocacy for the profession. Dr. Weedn stated that if we take care of our patients with our hearts we not only will swell our own hearts, but our patients will take care of us. He also stated that we have a common bond of education, experience, and commitment. We entered this profession with noble aspirations to help and care for our fellow man.

Dr. Weedn stated that the OSMA is not doing the same old things in the same old ways and it hasn't been in the last few years. The mission statement and goals have been refined and defined in an evolving long-range planning process. That long-range plan has been endorsed and approved by the House of Delegates. Dr. Weedn stated that the organization has become proactive instead of reactive. He stated that we will complement, not compete, with the county medical societies; to do that we must have enhanced dialog in communication in a simple, clear, and useful manner. With this understanding of a cooperative effort we will be stronger than we could ever be alone. Dr. Weedn stated that he will be communicating with each county medical society President in the next few weeks to get ideas on how to accomplish the OSMA goals and best be represented on the councils and committees.

In closing, Dr. Weedn stated that the major threat now to our success in representing members is internal deception and divisiveness. He stated that we must change the tone of the rhetoric and represent our patients and all our members successfully with integrity, fiscally and every other way.

VII. Recess
Dr. Bozalis declared a recess for the annual PLICO shareholders meeting and the OCVO annual report.

VIII. Annual PLICO Shareholders Meeting
The annual shareholders meeting of PLICO was convened in session by Floyd Miller, MD, PLICO Chairman.

Dr. Miller gave an update of PLICO malpractice as well as PLICO Health and asked for a motion to approve the PLICO annual report.

Motion was made, seconded, and passed to approve the PLICO annual report.

IX. Annual Report of the Oklahoma Centralized Verification Organization (OCVO)
Dr. Bozalis introduced Dr. Carey, who gave the report of the OCVO.

Dr. Carey stated that Reference Committee I will ask for the approval of the OCVO report and requested that this report be approved by the Delegates.

After a brief update of OCVO by Dr. Carey, Dr. Barbara Hastings presented Dr. Carey with a plaque for his work as chairman of OCVO for the 1999-2000 year.

Reconvene

X. Election Results
Dr. Storms declared the slots not contested, elected, and announced the election results.

President (one-year term)
Robert J. Weedn, MD, Duncan

President-Elect (one-year term)
Gary Strebel, MD, Oklahoma City

Vice President (one-year term)
W.F. Phelps, MD, Tulsa

Speaker, House of Delegates (two-year term)
Bruce L. Storms, MD, Chickasha

Vice Speaker, House of Delegates (two-year term)
David Russell, MD, Enid

AMA Delegates
Jack J. Beller, MD, Norman
Bruce L. Storms, MD, Chickasha
Jay A. Gregory, MD, Muskogee
W.F. Phelps, MD, Tulsa

AMA Alternate Delegates
Varsha R. Sikka, MD, Tulsa
Jennifer Trottman, MD, Tulsa
Kautilya Mehta, MD, Oklahoma City
Mayo Gilson, MD, Oklahoma City
William Bernhardt, MD, Oklahoma City

PLICO Board of Directors
William Coleman, MD, Oklahoma City
Scott Dunitz, MD, Tulsa
David Harper, MD, Tulsa
Michael Haugh, MD, Tulsa

OCVO Board of Managers
Varsha Sikka, MD, Tulsa
Noble Ballard, MD, Altus
Jan Chleborad, MD, Woodward

OSMA Trustee/Alternate Trustee Positions
District II (Kay, Noble, Osage, Pawnee, and Payne Counties)
Trustee: Richard Keim, MD
Alternate Trustee: Woody Jenkins, MD

District III (Garfield, Grant, Kingfisher, Major, Alfalfa, Woods, and Logan Counties)
Trustee: Sanku Rao, MD
Alternate Trustee: Phil Self, MD

District IV (Beaver, Cimmarron, Dewey, Ellis, Harper, Major, Texas, and Woodward Counties)
Trustee: Ed Calhoon, MD
Alternate Trustee: Jan Chleborad, MD

District V (Beckham, Blaine, Canadian, Custer, and Roger Mills Counties)
Trustee: Mike Talley, MD
Alternate Trustee: Curtis Schenk, MD

District IX (McIntosh, Muskogee, Okmulgee, Sequoyah, and Wagoner Counties)
Trustee: E.P. Couch, MD
Alternate Trustee: Joel Anderson, MD

District XIII (Caddo, Comanche, Cotton, Tillman, Grady, Jefferson, and Stephens Counties)
Trustee: Randall Jenkins, MD
Alternate Trustee: Kent King, MD

District XIV (Greer, Harmon, Jackson, Kiowa, and Washita Counties)
Trustee: no Trustee elected
Alternate Trustee: no Alternate elected

Dr. Storms congratulated the new officers and encouraged them to stay for the new officers luncheon and to remain for pictures after the Closing Session.

XIII. 2nd Reading - Bylaw Amendment
Dr. Storms stated that these changes were read for first reading last year and are located under Tab 1 in the handbook. He stated that there were four areas to be voted on and they were not debatable. Grammatical changes can be brought to the Speaker's attention:

1. Medical Student Section Representation to the House
2. Medical Student Representation on the OSMA Board of Trustees
3. Trustee Re-apportionment
4. Planning & Development Council Chair change

Amendments were passed by the House.

XIV. Reference Committee Reports
Dr. Storms informed the Delegation of the procedures for the Reference Committee Reports. All amendments will need to be made in writing and given to the Tellers. The Reference Committee Reports are divided into items for discussion and a consent calendar which will state: adopted, filed for information, or not adopted. Dr. Storms stated as a procedural matter there are items in the Reference Committee 1 report that will require a written ballot: OSMA Dues Increase and De-unification. Tellers will distribute ballots to credentialed Delegates that have an orange sticker on their badge. Ballots will be collected and counted. Dr. Storms stated that resolutions or reports requiring a bylaw change must pass the House by a two-thirds majority vote of the Delegates present and voting. All other reports and resolutions require a simple majority.

Report of Reference Committee III - Michael Talley, MD
Mr. Speaker and members of the House of Delegates:

Reference Committee III gave careful consideration to the several items referred to it and submits the following report.

Mr. Speaker, your Reference Committee recommends to adopt the following reports and resolutions on the Consent Calendar:

Consent Calendar

8. **Report of the Council on Medical Education**

9. **Report of the Physician Recovery Committee**

3. **Resolution 7**
 Silent Preferred Provider Organization (PPO)

4. **Resolution 9**
 Health Care Financing Administration (HCFA) 1500 Claim Forms

Mr. Speaker, your Reference Committee recommends the following reports be filed for information:

Filed for Information

5. **Report of the Council on Governmental Activities**

6. **Report of the Council on State Legislation and Regulation**

7. **Report of the AMA Delegation**

8. **Report of the Council on Member Services**

9. **Report of the Education & Research Foundation**

10. **Report of the Committee on Medical Ethics and Competency**

11. **Report of the Physician Recovery Program**

12. **Report of the Commission on International Medical Graduates**

13. **Report of the Oklahoma Medical Political Action Committee (OMPAC)**

Mr. Speaker, your Reference Committee rec-

ommends to adopt the following reports and resolutions with changes listed below.

Recommended to be Adopted

14. Resolution 8
Interest Charged on Billing Aeeounts
Mr. Speaker, your Referenee Committee reeommends that Resolution 8 be adopted with the following amended resolve:

RESOLVED, That the Oklahoma State Medical Association and its legislative arms work with the Oklahoma State Legislature and/or the State Insurance Commission to enact legislation to permit physicians to charge interest to ~~insurance companies~~ third parties *on all accounts in excess of 45 days from billing.*

15. Resolution 10
Private Contraeting under Medieare
Mr. Speaker, your Referenee Committee reeommends that substitute Resolution 10 be adopted in lieu of Resolution 10:

~~*RESOLVED, That the Oklahoma State Medical Association actively lobby the Congress of the U.S. through the AMA, our OSMA federal lobbyist, and other avenues as appropriate for the passage of: "The Senior's Health Care Freedom Act" (HR 2867) as introduced by Representative Patrick Tooney (R-PA).*~~

RESOLVED, That the Oklahoma State Medical Association work for the passage of federal legislation to guarantee the rights of Seniors to contract privately for medical services regardless of Medicare status.

Mr. Speaker, your Reference Committee reeommends the following resolution not be adopted:

Reeommended not be Adopted

16. Late Resolution 12
Continuation of Medical Education and Indigent Care Mission of the University of Oklahoma Health Scienees Center

Mr. Speaker, your Referenee Committee reeommends adoption of the Report of Reference Committee III as a whole.

Mr. Speaker, this concludes the Report of Reference Committee III. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report. As Chairman, I would like to thank the other Reference Committee members and OSMA staff, Lydia Shirley and Erica Schwenneker.

Reference Committee II -
E. Bradley Garber, MD
Mr. Speaker and members of the House of Delegates:

Referenee Committee II gave careful consideration to the several items referred to it and submits the following report.

Mr. Speaker, your Reference Committee recommends to adopt the following reports and resolutions on the Consent Calendar:

Consent Calendar

1. Report of the Council on Planning and Development

2. Report of the Counеil on Publie Relations

3. Resolution 5
Water Fluoridation

Mr. Speaker, your Reference Committee reeommends the following reports be filed for information:

Filed for Information

4. Report of the Counеil on Medieal Services

5. Report of the Oklahoma Centralized Verification Organization (OCVO)

6. Report of the Physieians Liability Insurance Company (PLICO)

7. Report of the Council on Professional Communications

8. Report of the Council on Public and Mental Health

9. Report of the OSMA Allianee

10. Report of the Medical Students Seetion

11. Report of the Organized Medical Staff Seetion

12. Report of the Physicians' Campaign for a Healthier Oklahoma Task Force

Mr. Speaker, your Referenee Committee reeommends to adopt the following reports and resolutions with changes listed below:

Recommended to be Adopted

13. Resolution 6
Continuation of Available, Safe Blood Produets for State Citizens
Mr. Speaker, your Referenee Committee reeommends that Resolution 6 be adopted with the following amended resolve:

RESOLVED, That the physicians of the Oklahoma State Medical Association (OSMA) support increased reimbursement to blood centers through third parties to ensure the quality, safety and availability of blood products for the people in the state of Oklahoma. Further, physicians of the OSMA also encourage blood donations and the assistance of community organizations in providing grants/endowments to help support the continuing mission of community blood centers~~, such as the Oklahoma Blood Institute~~, operating within the state of Oklahoma.

14. Late Resolution 11
Therapeutie Shoes
Mr. Speaker, your Referenee Committee reeommends that Late Resolution 11 be adopted with the following grammatical word changes:

Line 22 — Change "provide" to "provided."

Mr. Speaker, your Reference Committee recommends adoption of the Report of Reference Committee II as a whole.

Mr. Speaker, this concludes the Report of Reference Committee II. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report. As Chairman, I would like to thank the other Reference Committee members and OSMA staff, Sue Graves and Joy Leuthard.

Report of Referenee Committee I -
Edward Brandt, Jr., MD
Mr. Speaker and members of the House of Delegates:

Reference Committee I gave eareful eonsideration to the several items referred to it and submits the following report.

Mr. Speaker, your Reference Committee reeommends to file the following reports for information:

Filed for Information

1. Supplemental Report of the Board of Trustees

2. Membership Report

3. Report of the Membership Task Force

Mr. Speaker, your Referenee Committee reeommends to adopt the following reports and resolutions with changes listed below.

Recommended to be Adopted

4. Report of the Appropriations and Audit Committee
Mr. Speaker, your Reference Committee reeommends that the Report of the Appropriations and Audit Committee be approved with the revised recommendation:

The OSMA House of Delegates authorizes the Audit Committees of both PLICO and OSMA to study and recommend if a change in auditing firms is appropriate and allow the OSMA Board of Trustees the authority to approve the recommended change.

5. Board of Trustees Report
Mr. Speaker, your Reference Committee recommends that Items 1, 2, 3, 4, 5 be adopted as listed below:

Item 1 - Approve transfer of the Loan and School Fund to the OSMA Education and Research Foundation to be used for financial assistance to medical students and residents.

Item 2 - Approve utilization of the currently restricted Tort Reform funds for OSMA legislative and political activities as outlined in the report.

Item 3 - Approve utilizing monies currently available in the OSMA's operating account to balance the proposed 2000 budget.

Item 4 - Approve an annual stipend of $12,000 for the Chair, OSMA Board of Trustees.

Item 5 - Approve the proposed 2000 budget as presented.

6. Report of the Constitution & Bylaws Committee
Mr. Speaker, your Reference Committee recommends that Item 1 of the Report of the Constitution & Bylaws Committee be forwarded back to the Constitution & Bylaws Committee for further study and report to the Board of Trustees before the 2001 winter meeting.

Item 1 - Payment due date and suspension due date

Mr. Speaker, your Reference Committee recommends that Items 2, 3, 4, 5 of the Report of the Constitution & Bylaws Committee be adopted as listed below:

Item 2 - Housekeeping changes in regards to:
a. Chapter I Section 4.00 Jurisdiction change: ~~Chapter XI~~ Chapter X pg. 3
b. Chapter I Section 4.01 Transfer change: ~~Chapter XI~~ Chapter X pg. 3

Item 3 - Chapter VI Section 4.01 Multiple Offices change: adding Immediate Past President pg. 15

Item 4 - Chapter IX Section 1.00 Standing Committees:
change: delete ~~Financial Aid to Education Committee~~ pg. 21
Section 5.0
Financial Aid to change:
delete section 5.00 & 5.01 pg. 23
Education Committee (re-numbering of sections following)
The Financial Aid to Education Committee has not been active for several years and any financial aid for educational purposes will fall under the guidelines of the Education & Research Foundation Board.

Item 5 - Trustee Representation:
Chapter V Section 1.00 Composition
change ~~500~~ 450 pg. 11

7. Report of the Secretary-Treasurer
Mr. Speaker, your Reference Committee recommends that Items 1, 2, 3, 4, and 6 of the Report of the Secretary-Treasurer to be filed or adopted as listed below:

Item 1 - File 1999 OSMA annual audit for information.

Item 2 - File 1999 OSMA year-end financial statement for information.

Item 3 - Approval of 2000 OSMA revised annual budget as printed.

Item 4 - File 2000 OSMA first quarter financial statement for information.

Item 6 - Commend the Finance, Personnel, and Compensation Committee for their diligent work in investigating options and implementing a change in OSMA investment policy whereby OSMA investments have provided an improved return on our invested reserve funds and our operating funds.

8. Resolution 3
Proposed Dues Increase for Oklahoma State Medical Association-Referral to the Board of Trustees for further study.
Mr. Speaker, your Reference Committee recommends that Resolution 3 be adopted.
After much discussion the recommendations of Reference Committee I regarding Item 8, Resolution 3 was not adopted. (Resolution 3: RESOLVED, That any proposal for a membership dues increase by the Oklahoma State Medical Association be returned to the Board of Trustees for further study and not be implemented during the 2000 annual meeting of the OSMA House of Delegates.)

9. Report of the Secretary-Treasurer – Item 5, Report of the Board of Trustees – Item 6
Mr. Speaker, your Reference Committee recommends that Item 5 of the Report of the Secretary-Treasurer be adopted as amended:

Item 5 - Set 2001 dues for OSMA members at ~~$400~~ $300 per year.

Item 6 - Board of Trustees Report: Approve assessment of Association dues for active members at ~~$400~~ $300 effective 2001.

After much discussion, a written ballot was taken and the recommendations of Reference Committee I, Item 9, Report of the Secretary-Treasurer - Item 5 & Report of the Board of Trustees - Item 6 - *regarding OSMA dues was adopted as amended by a 153-22 vote:*

Item 5 - Set 2001 dues for OSMA members at $400 ~~$300~~ per year.

Item 6 - Board of Trustees Report: Approve assessment of Association dues for active members at $400 ~~$300~~ effective 2001.

10. Report of the Constitution & Bylaws Committee – Item 6
Resolution 1
De-unification from the AMA

Resolution 2
Deletion of AMA Membership Requirement

Item 6 - De-unification:
The attached bylaw revisions were submitted for consideration and approval.

Mr. Speaker, your Reference Committee considered Resolution 1 and 2 as well as Item 6 of the Constitution & Bylaws Committee and recommends in lieu of Resolution 1 and 2 adoption of Item 6 of the Report of the Constitution & Bylaws Committee.

After much discussion, a written ballot was taken and the recommendations of Reference Committee I regarding Item 10 - Resolutions 1 & 2 and Item 6 of the Constitution & Bylaws report, De-unification was not adopted by a vote of 87-88 in favor of not adopting. (Amendments to the bylaws, after being presented to the Bylaws Committee and if passed by the Board of Trustees on or before the Board's winter meeting, will be presented to the House of Delegates, and if passed by a two-thirds vote of the Delegates present and voting, will become effective at the close of the Annual meeting at which time it was passed.)

Dr. Storms asked for a point of personal privilege and addressed the Delegates. Dr. Storms stated that there were valid reasons expressed for unification and de-unification, and that those expressions were given in a professional, passionate manner with friends agreeing to disagree. Dr. Storms stated that he wanted the Association to remain strong and that this was obviously an issue that divided the members, but not to let this one issue destroy the organization. He guaranteed the Delegates that as part of the leadership of the Association as both Speaker and Delegate to the AMA that he has listened to what has been said and will encourage increased communication and increased unity. Dr. Storms thanked the Delegates for the decorum that this meeting has observed and is grateful that he was allowed to conduct the business of the House. Dr. Storms then asked for other comments.

After several comments from the Delegates, the Reference Committee Chairman began the completion of the report.

Mr. Speaker, your Reference Committee recommends the following resolution not be adopted:

Recommended not be Adopted

11. Resolution 4
Oklahoma State Medical Association (OSMA) Balanced Budget

Mr. Speaker, your Reference Committee recommends adoption of the Report of Reference Committee I as a whole.

Mr. Speaker, this concludes the Report of Reference Committee I. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report. As Chairman, I would like to thank the other Reference Committee members and OSMA staff, Kathy Musson and Barbara Matthews.

XV. Other Business
Dr. Storms thanked all the Delegates for their participation in the Reference Committee meetings, CME sessions, and other activities of the Annual Meeting.

Dr. Storms reminded the new officers to remain in the lobby for pictures and that a luncheon for the new officers will be held in the Sycamore Room immediately following. MD asked for a point of personal privilege.

XVI. Adjournment
A motion was made to adjourn the 94th Annual Meeting of the House of Delegates. Next year's meeting will be held at The Westin hotel in Oklahoma City on April 26-29, 2001.

REFERENCE COMMITTEE I

REPORT OF THE APPROPRIATIONS AND AUDIT COMMITTEE

ADOPTED AS AMENDED
Subject: Annual Report
Presented by: Mark C. Johnson, MD, Chair
Referred to: Reference Committee I
(A-2000)

Introduction
The Appropriations and Audit Committee is responsible for review of the annual audit of the financial statements of the OSMA.

Review of Activities
The Appropriations and Audit Committee met on March 1, 2000 and again on April 3, 2000 at the OSMA Headquarters.

At its March meeting, the Committee reviewed the draft report of the 1999 OSMA Audit, as prepared by Ernst and Young, LLP and presented by J. Matthew Darden (via teleconference). Mr. Darden discussed the appropriate audit procedures and protocols. C. Wallace Hooser, MD, and Michele Seba, Executive Director, Oklahoma Centralized Verification Organization (OCVO) also joined the following Committee members and guests via teleconference to review the reports/statements and answer questions: Mark C. Johnson, MD, Chair; Jack J. Beller, MD, Secretary-Treasurer; Robert J. Weedn, MD, President-elect; Boyd O. Whitlock, MD, President; David S. Russell, MD, Chair, Board of Trustees; Dale Neikirk, CPA, Assistant Secretary-Treasurer, Physicians Liability Insurance Company (PLICO); Brian O. Foy, OSMA Executive Director; and Shirley Burnett, OSMA Comptroller.

Highlights of the audit:

- The most significant change in 1999 was OSMA's purchase of the assets of OCVO; as this was an investment in a consolidated subsidiary, the OSMA balance sheets had to be adjusted to reflect this investment as an asset. The net result of this adjustment is that OSMA finished the year with a $59,514 **increase** in net assets.

- It was noted that the auditors and PLICO had not yet received the expected confirmation from the Oklahoma Department of Insurance that the Commissioner would continue to allow PLICO to operate its reserves at a discounted range.

The Appropriations and Audit Committee approved the draft audit reports as presented by Ernst & Young, LLP, pending the confirmation concerning PLICO. This confirmation was received in early April. Copies of the final reports are included as an attachment to the Report of the Secretary-Treasurer.

On April 3, 2000, the Audit Committee conducted a joint meeting with representatives of the PLICO Audit Committee. Following expressed concerns and discussion there was unanimous agreement for the OSMA and PLICO to determine if a change in auditors would be prudent.

Recommendation
Consistent with the intent of Resolution 30, which the OSMA House of Delegates adopted in 1996 (see Attachment I), the OSMA Audit Committee (with the concurrence of the PLICO Audit Committee) recommends the following:

~~THE OSMA HOUSE OF DELEGATES DIRECT THE AUDIT COMMITTEES OF BOTH PLICO AND OSMA AS A MATTER OF DUE DILIGENCE TO DETERMINE IF A CHANGE IN THE CURRENT AUDIT FIRM IS BOTH PRUDENT AND EFFICACIOUS.~~

The OSMA House of Delegates authorizes the Audit Committees of both PLICO and OSMA to study and recommend if a change in auditing firms is appropriate and allow the OSMA Board of Trustees the authority to approve the recommended change.

Respectfully submitted,
Mark Johnson, MD, Chair

ATTACHMENT I

Resolution 30, A-96
Uniform Auditing Firm Changes for PLICO and OSMA

Whereas, The Oklahoma State Medical Association (OSMA) and the Physicians Liability Insurance Company (PLICO) are separate entities, both under separate boards of directors, but directly governed by the OSMA House of Delegates; and

Whereas, It is appropriate business practice to audit PLICO and OSMA on a regular basis; and

Whereas, The change of auditing firms for PLICO and OSMA has multiple important ramifications with significant mone-

tary costs involved; now therefore be it

RESOLVED, That future PLICO and OSMA auditing firm changes be concurrent; and be it further

RESOLVED, That the OSMA and PLICO change the auditing firm to Ernst & Young for 1996 and that future changes of the auditing firms be initiated after:

1. The audit committee of either PLICO or OSMA boards have been notified of problems with the current auditing firm, by OSMA or PLICO members or directors; and
2. The concerned audit committee has by majority voted that a concern exists and the committee will arrange:
 a.) a presentation by PLICO or OSMA staff, members, or directors, representing both sides of the issue for the following House of Delegates annual meeting where…
 1.) an informed House of Delegates can then, by the usual simple majority, direct the audit committees to BOTH the PLICO and OSMA boards, by resolutions, to seek bids and pursue auditing firm changes.

REPORT OF THE BOARD OF TRUSTEES

ADOPTED
Subject: Annual Report
Presented by: David S. Russell, MD, Chair
Referred to: Reference Committee I
(A-2000)

Introduction

Your OSMA Board of Trustees has been exceptionally busy since the 1999 Annual Meeting, carrying out the mandates from our membership for an association not just active but proactive in meeting the ever-increasing challenges to our profession and to our ability to set the standards of care for our patients. To accomplish this, one additional Board meeting was added, bringing to five the meetings scheduled for the 1999-2000 organizational year. As of this report, four of the scheduled meetings have been held. The fifth of the regularly scheduled meetings will be held on May 4th just prior to the 2000 Annual Meeting of the OSMA; the proceedings of this meeting will be contained in a Supplemental Report of the Board of Trustees to the House of Delegates.

During the past organizational year, the Board met in scheduled sessions on May 23, 1999, November 14, 1999, and February 6, 2000 in Oklahoma City and August 29, 1999 in Tulsa. A quorum was certified for the conduct of business at each meeting.

Council, Committee, and Special Reports

During each meeting, OSMA Councils, Standing Committees, Special Sections and Ad Hoc Committees presented reports to the Board. The Board also heard reports from PLICO, OCVO, and the OSMA Alliance. As each of the entities also report directly to the House of Delegates, their reports will not be presented here except for any special actions taken by the Board.

Report of Board Actions

Outlined below are actions taken by the Board of Trustees at each of their meetings following review and consideration of information and recommendations presented.

At the meeting of May 23, 1999, in Oklahoma City, the Board:

- Approved the minutes of the April 15, 1999 Board meeting as amended to include David M. Selby, MD, as an attendee.

- Accepted Resolution 14, Mandated Insurance Coverage for Contraceptive Services, as rewritten. The resolution was referred to the Board by the 1999 House of Delegates for review; Ms. Linda Scoggins, OSMA Legal Counsel, rewrote the resolution to comply with the concerns expressed by the House. The resolution as rewritten and accepted was referred to the Council on State Legislation and Regulation for implementation.

- Approved the Report of the Secretary-Treasurer and the OSMA Financial Statement as presented.

- Heard a report from Mr. Thomas Kielhorn from Thomas Kielhorn & Associates, an Oklahoma City public opinion firm commissioned by the OSMA to determine the public's response to scope of practice issues and if an initiative petition to amend the Oklahoma Constitution to establish a board to decide scope of practice questions could be successful. Poll results showed that the public has a positive image of Oklahoma physicians and feel they are receiving good care; however, Mr. Kielhorn did not feel that the results indicate with certainty an initiative petition would be successful. Following the presentation, the Board adopted a **motion** to discontinue further consideration of an initiative petition drive.

At the meeting of August 29, 1999, in Tulsa, the Board:

- Approved the minutes of the May 23, 1999 Board meeting as written.

- Following a tribute by Jay A. Gregory, MD, the Board observed a moment of silence in memory of Perry Lambird, MD.

- Seated Steven Ortlip, MD, as Alternate Trustee from District XI.

- Adopted a motion that, although OSMA policy states that all Tobacco Settlement Funds go to programs for prevention, cessation, treatment of tobacco related diseases, and research, authorizes the chair of the Council on State Legislation to negotiate for the maximum amount of tobacco settlement funds to achieve these purposes and to participate in coalitions toward that end, and that OSMA makes the Tobacco Settlement issue the top legislative priority for the 2000 session.

- Approved the Secretary-Treasurer Report and the OSMA Financial Report as presented.

- Approved two recommendations from the Council on Medical Education to:
 1. appoint a Task Force composed of members of the OSMA Board of Trustees and the Council on Medical Education to determine the costs of OSMA becoming accredited as Category 1 provider; to compare cost of OSMA providing Category 1 programs verses cost of outsourcing; and to determine the rationale for OSMA seeking accreditation; and
 2. approve the Annual Meeting course suggestions as listed:

2 hours	Substance Abuse
2 hours	Cardiovascular
1 hour	Contract Review
2 hours	PLICO Loss Prevention
1 hour	Medical Ethics
1 hour	HCFA National Projects (½) OBMLS CME requirements (½)
1 hour	Medicare Compliance

- Selected Jack J. Beller, MD, to complete the AMA Delegate term of Perry A. Lambird, MD. The Board determined that the OSMA President would complete the AMA Alternate Delegate term of Dr. Beller.

- Approved the recommendations of the Membership Task Force to:
 1. delete non-members from the OSMA Directory of Physicians;
 2. approve the AMA dues pilot program for the year 2000; and
 3. refer to the Bylaws Committee for implementation of delinquency date changes in OSMA Bylaws to correspond with AMA delinquency dates.

• Submitted to the Speaker of the House and Viee-Speaker for their consideration the following suggestions compiled by the Ad Hoe Committee on the Annual Meeting:

1. polling the delegates at the 2000 meeting for their recommendations on the length of the Annual Meeting, 2 or 3 days;
2. expanding CME eourses and eoordinating CME activities with state specialty society meetings in eonjunction with the Annual Meeting. All CME Courses offered should be under the direction of the Council on Medical Education;
3. developing sponsorships with pharmaceutical companies to finance reeeptions, dinners, etc; and
4. limiting the number of complimentary tickets to the Inaugural Banquet.

• Noted that, at the Annual Meeting of the AMA Alliance in Chicago in June, Susan Paddack from Ada was installed as President-eleet of the AMA Alliance for the 1999-2000 year and Barbara Jett from Oklahoma City was appointed Chair of the AMA Foundation Committee.

• In conjunction with this meeting, adjourned the meeting of the OSMA Board and convened a meeting of the voting members of the OSMA Education and Research Foundation. The voting members approved amendments to the Foundation Bylaws reeommended by the Foundation Board of Directors.

• Due to a lack of a quorum, the following applications for Life Membership and Special Membership submitted for review at this meeting were mailed to the Board and were approved by mail ballot:

Life Memberships:
Leonard H. Brown, MD, Jenks
William R. Paschal, MD, Buena Vista, Colorado
William R. Patton, MD, Norman

Special Membership Applications:
Merle D. Carter, MD, Oklahoma City
Dan E. Miller, MD, Tulsa
Kelly B. Singer, MD, Tulsa
Robert W. Gibson, MD, Ponea City
William J. Hale, MD, Edmond
Gary W. Harris, MD, Edmond
Ahmet Koker, MD, Oklahoma City
Malcolm Robinson, MD, Oklahoma City

At the meeting of November 14, 1999, in Oklahoma City, the Board:

• Heard a report from Oklahoma's Lt. Governor Mary Fallin on health care issues to be considered in the upcoming legislative session, including Workers Comp reform. The Lt. Governor eommended Dr. Weedn and the OSMA for the Physicians' Campaign for a Healthier Oklahoma.

• Approved the minutes as written of the Board meeting of August 29, 1999.

• Seated Mason Jett, MD, as an Alternate Trustee from District VI.

• Reviewed the report of the Ad Hoe Committee on Firearm Safety and approved, as amended by the Committee, Resolution 12, Firearm Safety and Children, referred by the 1999 House of Delegates.

• Approved individually the reeommendations of the Finance, Personnel, and Compensation Committee to:

1. adopt the Statement of Investment Policy, Objectives and Guidelines as outlined by the Committee; and
2. approve the selection of Russ Pyle, Senior Vice President - Investments, Salomon Smith Barney, as the OSMA's new Financial Advisor, effective immediately.

• Approved individually the recommendations of the Secretary-Treasurer to:

1. reeommend to the House of Delegates at the 2000 Annual Meeting the release of the Temporarily Restricted Funds for "Tort Reform" and "Loan and School" to the unrestricted operating fund;
2. recommend to the House of Delegates at the 2000 Annual Meeting that the dues for regular active members be set at $400 effeetive January 2001;
3. approve an annual stipend of $12,000 for the Chairman of the Board of Trustees;
4. approve the proposed 2000 budget; and
5. approve the Seeretary-Treasurer report as written.

• Adopted the OSMA 1999-2000 Legislative Goals as recommended by the Counеil on State Legislation and Regulation.

• Approved the recommendations of the Constitution and Bylaws Committee which included the recommendations that:

1. each trustee district would be entitled to one Trustee for every 450, currently 500, physician members or fraetion thereof; and
2. all Trustees be re-elected in 2001.

• Endorsed as reeommended the initiatives of the Committee of Medieal Ethics and Competeney to expand its scope of services to physicians and to beeome a resouree to members on issues relating to medical ethics.

• On the recommendation of the Physicians Reeovery Program, approved:

1. the submitted changes to the Physicians Recovery Program Guidelines; and
2. the Colorado Physicians Edueation Program (CPEP) coming under the guidelines of the Physieians Recovery Program.

• Aeeepted the recommendations of the Membership Task Force that:

1. OSMA make membership a priority every year, focusing on membership recruitment and retention;
2. develop press releases and news eonferenees regarding the tobaeeo issue emphasizing that this is the number one priority of the OSMA. This will allow non-members to see the work the OSMA; and
3. aecomplish a one-time mailing of the OSMA new member brochure to all current OSMA members, osteopathic physician non-members, and the 600 non-members in the OSMA data base.

• Approved the recommendations of the CME Task Force that:

1. the Edueation & Research Foundation (ERF) apply for aecreditation through the OSMA Council on Medieal Education;
2. the ERF Board be authorized to establish a CME Planning Committee with an appropriate budget to apply for accreditation, and plan and implement CME programs; and
3. the OSMA Council on Medical Edueation and its budget be relocated from the Foundation to the OSMA general operating aeeount.

• Approved the reeommendation of the Council on Professional Communications to diseontinue the contract with Public Strategies no later than July 1, 2000, and the *Journal* be brought in-house.

• Approved the changes recommended by the Council on Public and Mental Health to Resolution 13, Substance Abuse Task Force, referred to the Board for review by the 1999 House of Delegates.

• Approved Life Membership applications of the following:
George W. Carlson, MD, Ardmore
William D. Heath, MD, Oklahoma City
Joe S. Hester, MD, Muskogee
John McIntyre, MD, Enid
Robert J. Outlaw, MD, Oklahoma City

• Approved Special Membership applications of the following:
Robert W. Daniels, MD, Midwest City
W. Richard Harrison, MD, Oklahoma City
William D. Hawley, MD, Oklahoma City
Jerry R. Hordinsky, MD, Oklahoma City
Fred L. Loper, MD, Oklahoma City
Alice E. McInnis, MD, Oklahoma City
Kim Braden McLanahan, MD, Edmond
Malcolm Robinson, MD, Oklahoma City
Franklin D. Barnett, MD, Midwest City
Daniel H. Carmichael, MD, Edmond
Erwin T. Janssen, MD, Tulsa
Dale H. Peterson, MD, Edmond
Richard W. Welch, MD, Oklahoma City

At the meeting of February 6, 2000, in Oklahoma City, the Board:

• Heard a report from Jerry Vannatta, MD, Dean of the OU College of Medicine outlining the clinical care, education, and research mission of the College: he also informed the Board of the OU College of Medicine's upcoming Centennial Celebration.

• Approved the minutes of the November 14, 1999, meeting as written and distributed.

• Approved the nominations of:
1. Attorney Drew Edmondson for the Don J. Blair Friend of Medicine award; and
2. Gordon H. Deckert, MD, for the OSMA Community Service Award.

• Approved the Secretary-Treasurer report and the OSMA Financial Statement as presented through December 31, 1999.

• Accepted the budgetary adjustments, as amended, recommended by the Executive Committee to the proposed 2000 budget. The adjustments to both revenue and expenses resulted in a net $123,300 decrease in the proposed 2000 budget.

• Approved the recommendations of the Executive Committee that the OSMA Board of Trustees recommend to the House of Delegates at the 2000 Annual Meeting that the Loan and School Fund remain restricted and be transferred to the OSMA Education and Research Foundation to be used for financial assistance to medical students and residents.

• Approved the recommendations of the Executive Committee that the OSMA Board of Trustees recommend to the OSMA House of Delegates at the 2000 Annual Meeting that the monies in the Tort Reform fund be utilized for OSMA legislative and political activities; that for the year 2000, $52,600 be used to supplement the budget for lobbying and the budget for Governmental Activities; and that the remainder be earmarked for similar services in the year 2001 and in subsequent years until the fund is accepted.

• Approved the recommendation of the Executive Committee that the OSMA Board of Trustees recommend to the House of Delegates at the 2000 Annual Meeting that the deficit in the proposed 2000 budget be taken from money currently available in OSMA's Operating Account.

• Reviewed and considered bylaws revisions developed by the Constitution and Bylaws Committee which would be to effect de-unification from the AMA. In accordance with the procedure established by the recently revised Chapter XIII of the OSMA Bylaws, the Board passed the submitted bylaws changes and forwarded them to the 2000 House of Delegates for their discussion and vote.

• Approved recommendations from the Constitution and Bylaws Committee to form a joint committee of the Membership and Bylaws Committee to:
1. develop guidelines based on information collected from other states for an equitable way to allow speciality society representation in the OSMA; and
2. review the current requirements for Life Membership.

The Joint Committee is to report to the Board no later than the 2001 winter meeting.

• Authorized Robert Weedn, MD, and the Physicians' Campaign for a Healthier Oklahoma (PCHO), working with our Legal Counsel to pursue opportunities to obtain underwriting for continued distribution of the Take Care Campaign vials.

• Approved recommendations from the Council on Medical Education regarding revised accreditation items and fee structure.

• Approved Life Membership applications of the following:
James H. Bearden, MD, Tulsa
William R. Bullock, Jr., MD, Yukon
Lyle W. Burroughs, MD, Oklahoma City
Billy Dale Dotter, MD, Oklahoma City
Robert E. Engles, MD, Durant
Samuel A. Ferris, MD, Tulsa
Lionel H. Fuller, Jr., MD, Choctaw
Gerald E. Gustafson, MD, Tulsa
William E. Harrison, Jr., MD, Owasso
Manuel J.A. Hinds, MD, Tulsa
Joe Horton, MD, Frederick
John W. Huneke, MD, Ada
John E. Kauth, MD, Tulsa
C.S. Lewis, MD, Tulsa
Robert F. Morgan, MD, Blackwell
R. Wayne Neal, MD, Tulsa
Edward O. Nonweiler, MD, Tulsa
Clarence R. Roberts II, MD, Enid
Jerry Sisler, MD, Tulsa
Elias S. Srouji, MD, Oklahoma City
William C. Stone, MD, Tulsa
Richard F. Tenney, MD, Tulsa
Lewis W. Thompson, MD
Bruce E. Wenger, MD, Tulsa
Teresa Marie Williams, MD, Guthrie

• Approved Special Membership applications of the following:
Charles M. Berry, MD, Orange Beach, AL
F. Allen Bowers, MD, Oklahoma City
Gordon Deen, MD, Austin, TX
Arthur A. Hellman, MD, Cherry Hill, NJ
Frank D. Lewis, MD, Ruidoso, NM
Hans P. Norberg, MD, Tulsa
R. Robert Reid, MD, Springfield, MO
Kim Zarintash, MD, Fairland

Recommendations

1. Approve transfer of the Loan and School Fund to the OSMA Education and Research Foundation to be used for financial assistance to medical students and residents.
2. Approve utilization of the currently restricted Tort Reform funds for OSMA legislative and political activities as outlined in the report.
3. Approve utilizing monies currently available in the OSMA's Operating Account to balance the proposed 2000 budget.
4. Approve an annual stipend of $12,000 for the Chair, OSMA Board of Trustees.
5. Approve the proposed 2000 budget as presented.
6. Approve assessment of Association dues for active members at $400 effective 2001.

Comments

The Board hosted an awards ceremony in the OSMA Headquarters board room on June 7, 1999, to present to Mr. Bobby Murcer the Don J. Blair Friend of Medicine Award. Mr. Murcer was unable to attend the 1999 Annual Meeting for presentation of the Award. Dr. John Bozalis made the presentation.

During the morning of February 6, 2000, prior to the afternoon Board meeting, the Trustees participated in a seminar on "Boardmanship" presented by Norman H. Hammon from The Center for Nonprofit Management. The purpose of the seminar was to define the duties and responsibilities of boards of trustees of not-for-profit organizations and to identify ways to most effectively and efficiently accomplish these.

Your Board, this past year, tackled many tough issues including the question of de-unification from the AMA and the current and future financial security of our Association. These issues, as well as others, are not always easy to resolve; your Board struggled in good faith to arrive at solutions which would be in the best interests of our Association and its entire membership. Several issues, as outlined in the report, have been referred to the House of Delegates for review and decision. Putting aside regional interests and focusing on the good of the entire organization must always be our goal if the Association is to continue to thrive and to continue to be an effective advocate for the physicians of Oklahoma.

Respectfully submitted,
David S. Russell, MD, Chair

SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES

FILED FOR INFORMATION
Subject: Annual Report
Presented by: David S. Russell, MD, Chair
Referred to: Reference Committee I (A-2000)

The Annual Meeting of the Board of Trustees, in accordance with Association Bylaws, convened yesterday, May 4, 2000, at 1:00 p.m. at The Westin Hotel, Oklahoma City, Oklahoma. This Supplemental Report reviews actions taken by the Board at the meeting. The Report will be referred to Reference Committee I for consideration in conjunction with the Annual Report of the Board of Trustees, which is included in the Delegates Handbook.

- Approved the minutes as corrected of the February 6, 2000, Board of Trustees meeting.

For the Board's information, the Chairman reviewed the items referred from the 1999 House of Delegates meeting to the Board for further study and action. Four items were referred:

1. Resolution 2 - Electronic Pre-Certification: an Ad Hoc Committee established by the Council on Medical Services is working with HMO medical directors to develop a standardized form.
2. Resolution 12 - Firearm Safety and Children: amended resolution developed by an ad hoc committee chaired by Dr. William Hall adopted by the Board on November 14, 1999. Amended Resolve attached (see Attachment I).
3. Resolution 13 - Substance Abuse Task Force: second resolve referred to Council on Public and Mental Health. Substance Abuse Task Force of Council submitted an amended resolution adopted by the Board on November 14, 1999. Amended Resolve attached (see Attachment II).
4. Resolution 14 - Mandated Insurance Coverage for Contraceptive Services: wording changes to reflect the sense of the House of Delegates formulated by OSMA legal counsel. Resolution referred to Council on State Legislation and Regulation for legislative action. Bill to implement, SB 222, currently active in legislative process.

- Approved the OSMA Goals and Initiatives as revised by the Council on Planning and Development (see Council on Planning & Development Report in Reference Committee II).

- Approved the Report of the Secretary-Treasurer including:
1. the OSMA Annual Audit for the year 1999,
2. the OSMA financial statements for the calendar year ending December 31, 1999, and
3. the OSMA financial statements for the 1st calendar quarter ending March 31, 2000.

- Approved by consensus the formation of a committee to review and to obtain review from our legal counsel and from PLICO the draft of the Joint Statement on Medical-Legal Interprofessional Conduct as proposed by the Oklahoma Bar Association's Rules of Professional Conduct Committee.

- Approved a request from the Council on State Legislation and Regulation granting the Council authority to negotiate for the maximum amount of tobacco settlement funds which can be obtained in order to meet the objectives of previously set OSMA policy.

- Accepted the recommendations of the OSMA *Journal* Editorial Board to:
1. re-appoint to one-year terms as Associate Editors of the OSMA *Journal:*
 J. Michael McGee, MD
 Ruth H. Oneson, MD
 Johnny B. Roy, MD
 Clifford G. Wlodaver, MD
2. appoint David M. Selby, MD, to a three-year term as Editor, and
3. continue stipends at the current rate of $500/mo for the Editor-in-Chief and $200/year for Editors.

- Accepted the recommendation of the Audit and Appropriations Committee to direct the Audit Committees of OSMA and PLICO to determine if a change in the current audit firm would be prudent and efficacious (see Audit and Appropriations Committee report in Reference Committee I).

- Approved the Special Membership requests as presented with additions.

- Approved for referral to the House of Delegates the following late resolutions:
 11: Therapeutic Shoes
 12: Continuation of Medical Education and Indigent Care Mission of the University of Oklahoma Health Sciences Center.

- Accepted the resignation of David L. Harper, MD, from the Board of Trustees from District VIII effective immediately. In accordance with the Association bylaws, the position was automatically filled by David Nierenberg, MD.

- Elected for the coming year:
 Mark Johnson, MD, Chairman, Board of Trustees
 David Nierenberg, MD, Vice-chair, Board of Trustees

- In Executive Session the Board adopted as policy the opinion of OSMA's legal counsel regarding the implementation process of de-unification if proposed bylaw changes are adopted.

- Approved the Life Memberships of the following physicians:
 John A. Blaschke, MD, Oklahoma City
 George H. Davis, MD, Seminole
 Dean H. Diment, MD, Tulsa

Loretta G. Engles, MD, Midwest City
Richard F. Harper, MD, Edmond
Bob Hoke, MD, Norman
William G. Mays, MD, Tulsa
Joseph F. Messenbaugh III, MD, Oklahoma City
William Morris, MD, Oklahoma City
Samuel R. Oleinick, MD, Tulsa
Asa Standley Porter, MD, Oklahoma City
John M. Salmeron, MD, Oklahoma City
Robert B. Zumwalt, MD, Tecumseh
David M. Eggenberg, MD, Davis
Robert L. Olson, MD, Oklahoma City

- Approved Special Membership applications for the following:

Roy W. Dowdell, MD, Oklahoma City
Mary Apple Frow, MD, Oklahoma City
Ahmet Koker, MD, Oklahoma City
Robert A. Taylor, MD, Tulsa
Jack A. Barney, MD, Oklahoma City
William S. Conkling, MD, Oklahoma City
Colleen R. Boucher, MD, Oklahoma City
Sung A. Lee, MD, Tulsa
Sharon A. Rose, MD, Oklahoma City

Respectfully submitted,
David S. Russell, MD, Chair

ATTACHMENT I

Referred to the Board of Trustees for further study
Resolution 12: Firearm Safety and Children (A-99)

Resolves as amended and approved by the Board of Trustees:

RESOLVED, That the OSMA encourage the:

a) developing of educational materials on firearm safety for distribution to lay groups including but not limited to school board organizations such as PTAs, Boards of Education, Health Lifestyles initiatives and state health agencies and for distribution by the media where possible; this information should emphasize learning or principles that guns or firearms found by a child should ***spur*** *the child to immediately search out an adult to handle the gun or to get help versus the child attempting to unload or otherwise handle the firearm himself/herself. The same principle applies to ammunition found.*

b) maintaining already established waiting period for firearm purchase as well as background checks ("instacheck") required for all firearm purchases and support funding sufficient for local law enforcement agencies to enforce this legal restriction.

RESOLVED, the OSMA *advocates*:

a) developing **Child Access Prevention (CAP)** laws similar to those now held by at least *17* states, which hold parents or guardians criminally liable if a child gains access to their improperly stored firearm and uses it in an intentional or unintentional injury to themselves or to another person.

b) physician participation in, particularly by primary care physicians, efforts to educate patients to the general dangers of unsupervised firearm access by children and to the following principles in particular:

1) no child under 15 coming upon a firearm or an apparent piece of ammunition should pick up or handle the found object but instead should immediately leave and seek out an adult to examine and unload or disarm the weapon.

2) a child witnessing another child whether friend or stranger carrying a firearm should immediately walk away and seek an adult for advice and counsel on what action is appropriate.

3) firearms in the home should be stored under lock and key.

ATTACHMENT II

Referred to the Board of Trustees for further study
Resolution 13: Substance Abuse Task Force (A-99)

Whereas, *The State of the State's Health Report* published on March 3, 1999 demonstrated that substance abuse-related mortality is a major cause of death and the leading cause of potential years of lives lost; and

Whereas, On March 26, 1997, Governor Frank Keating issued Executive Order 97-06 creating a special Governor's Task Force on Substance Abuse; and

Whereas, The 15 members of the Task Force, with the cooperation of the agencies of the state government and the major state universities, issued their report on substance abuse in Oklahoma in May of 1998; and

Whereas, This report made several recommendations to decrease substance abuse in Oklahoma; therefore be it

RESOLVED, That the OSMA publicly commend Governor Keating and his Substance Abuse Task Force for this great service to the people of Oklahoma; and be it further

RESOLVED, That the OSMA endorse and actively support the following recommendations:

1. Oklahoma's prevention, education, and treatment functions related to substance abuse should be consolidated under the auspices of a distinct, centralized agency which has as its central focus the problem of substance abuse.

 1a.) A secondary primary recommendation related to the first, should the concept of a separate umbrella substance abuse agency not be implemented: an expansion of the Mental Health Board from seven to 10 members, with the three additional members drawn from the field of substance abuse treatment.

2. All clients seeking or sentenced to services from state agencies (welfare, unemployment, prisons, juvenile justice, mental health, etc.) should be thoroughly assessed for signs of substance abuse and be encouraged, and where appropriate, required to enroll in counseling, treatment or prevention programs administered by private agencies or by the Department of Mental Health and Substance Abuse Services ~~proposed Department of Substance Abuse~~. This is especially vital for those entering the criminal justice system, where untreated substance abuse is a primary indicator of recidivism.

3. Oklahoma should prohibit the sale of cold canned or bottled beer for off-premises consumption.

4. Licensing and enforcement of laws related to low-point beer should be transferred to the ABLE Commission. This function could be funded by increasing beer license fees.

5. In-prison substance abuse treatment programs should be broadly expanded throughout Oklahoma's penal and juvenile justice systems. Every long-term incarceration facility should implement and make available programs like the successful PRIDE effort (a volunteer, therapeutic community currently in a private prison in Holdenville, OK). For inmates assessed as having primary substance abuse problems, successful treatment and continued urinalysis and

participation in recovery programs should be a primary condition of release from state custody.

6. Oklahoma should reduce the DUI threshold from .10 to .08.

7. ~~Oklahoma should pass and rigorously enforce a vehicle seizure law that leads to the confiscation of vehicles driven by second and subsequent DUI offenders.~~

8. ~~The proposed Department of Substance Abuse should conduct a detailed annual survey of drug and alcohol use among young people, providing a periodic "pulse" measuring the effectiveness of prevention programs. We test students each year for math mastery; we should also sample for behaviors that could kill them.~~

9. ~~The Law Enforcement Partnerships of the Governor's Discretionary Fund currently allocates just 10 percent of its $1 million annual budget to effective law enforcement school partnerships like the DARE program; half of the partnerships funds underwrite area prevention resource centers which are one step removed from actual classroom lessons. Law enforcement partnerships should receive at least 25 percent (approximately $1 per student) of these funds, and every effort should be made to assure that drug free school funds are spent in the classroom where they are most effective.~~

10. ~~All~~ A portion of state taxes collected on beer and distilled spirits which are directed to the General Fund should be allocated for substance abuse treatment.

11. ~~If Oklahoma receives funds from a projected national tobacco settlement, a substantial portion of those funds should be utilized to support effective substance abuse prevention programs.~~

12. Education in substance abuse should be a mandatory part of the teacher preparation process in our colleges and universities.

13. All state agencies should develop and implement a comprehensive pre-employment, random and a for-cause drug and alcohol testing program, supported by the Office of Personnel Management's Employee Assistance Program with a substance abuse program to provide services and support for those identified.

■ REPORT OF THE OSMA MEMBERSHIP DEPARTMENT

FILED FOR INFORMATION
Subject: Life Memberships
Presented by: Kaye Boroughs, OSMA Membership Coordinator
Referred to: Reference Committee 1 (A-2000)

Review of Activities
The OSMA Board of Trustees has granted life membership to the following physicians since the last House of Delegates meeting in April of 1999:

August 29, 1999 Board Meeting:
Leonard H. Brown, MD, Jenks
William R. Paschal, MD, Oklahoma County
William R. Patton, MD, Norman

November 14, 1999 Board Meeting:
William D. Heath, MD, Oklahoma City
Joe S. Hester, MD, Muskogee
Robert J. Outlaw, MD, Oklahoma City

February 6, 2000 Board Meeting:
James H. Bearden, MD, Tulsa
William R. Bullock Jr., MD, Yukon
Lyle W. Burroughs, MD, Oklahoma City
Billy Dale Dotter, MD, Okeene
Robert E. Engles, MD, Durant
Samuel A. Ferris, MD, Tulsa
Lionel H. Fuller Jr., MD, Choctaw
Gerald E. Gustafson, MD, Tulsa
William E. Harrison Jr., MD, Owasso
Manuel J.A. Hinds, MD, Tulsa
Joe Horton, MD, Frederick
John W. Huneke, MD, Ada
John E. Kauth, MD, Tulsa
C.S. Lewis Jr., MD, Tulsa
Robert F. Morgan, MD, Blackwell
R. Wayne Neal, MD, Tulsa
Edward O. Nonweiler, MD, Tulsa
Clarence R. Roberts II, MD, Enid
Jerry Sisler, MD, Tulsa
Elias S. Srouji, MD, Oklahoma City
William C. Stone, MD, Tulsa
Richard F. Tenney, MD, Tulsa
Lewis W. Thompson, MD
Bruce E. Winger, MD, Tulsa
Teresa Marie Williams, MD, Guthrie

As stated in Chapter 1, Section 2.031 of the OSMA Constitution and Bylaws, these physicians must be approved for life membership by the House of Delegates at the Annual Meeting.

■ REPORT OF THE SECRETARY-TREASURER

ADOPTED AS AMENDED
Subject: Annual Report
Presented by: Jack J. Beller, MD, Secretary-Treasurer
Referred to: Reference Committee 1 (A-2000)

Introduction
Enclosed is the annual report of the Secretary-Treasurer of the Oklahoma State Medical Association to the House of Delegates, which contains the following information:

1. 1999 OSMA Annual Audit by Ernst & Young, LLP;
2. 1999 Year-End Financial Statement;
3. 2000 OSMA First Quarter Financial Statement; and
4. 2000 OSMA Revised Annual Budget.

Background
Throughout 1999, quarterly reports have been made to the OSMA Board of Trustees by the Secretary-Treasurer outlining the financial condition of the OSMA including a financial statement for the Oklahoma State Medical Association, the OSMA Education and Research Foundation, and the OSMA Member Services For-Profit Corporation. The Board of Trustees has approved each of the quarterly reports.

1999 Annual Audit
Attachment 1 is the "Report of Independent Auditors" prepared by Ernst & Young, LLP. The auditing firm found no problems with the financial records. Their conclusion is that the financial statements "present fairly, and in all material aspects, the financial position of the Oklahoma State Medical Association, as of December 31, 1999 and 1998, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States." The cost to OSMA for the audit was $7,200 plus expenses of $1,080 for a total of $8,280.

1999 Year-End Financial Statement
The 1999 Year-End Financial Statements of the OSMA, the OSMA Education and Research Foundation, and the OSMA Member Services For-Profit Corporation are included as a part of Attachment 1. It should be noted that, as a result of auditor adjustments, the OSMA finished the year

OSMA Statements of Financial Position

	December 31 1999	1998
Assets		
Cash and cash equivalents	**$ 1,130,864**	$ 1,514,333
Investments	**1,649,042**	1,200,355
Accounts receivable, primarily membership dues	**1,445,872**	1,844,776
Prepaid expenses	**14,403**	15,267
Property and equipment, at cost:		
Land	**7,808**	7,808
Building and improvements	**494,322**	494,322
Furniture, fixtures, and equipment	**621,493**	584,506
	1,123,623	1,086,636
Less accumulated depreciation and amortization	**(586,392)**	(495,547)
	537,231	591,089
Other investments:		
Investment in PLICO	**15,302,775**	15,302,775
Equity in uncansolidated subsidiary - OCVO	**140,753**	–
Equity in unconsolidated subsidiary - MSC	**12,978**	44,903
	15,456,506	15,347,678
Total assets	**$ 20,233,918**	$20,513,498
Liabilities and Net Assets		
Accounts payable	**$ 872,885**	$ 1,210,739
Deferred membership dues	**1,142,063**	1,143,303
Total liabilities	**2,014,948**	2,354,042
Net assets:		
Unrestricted	**2,648,697**	2,598,900
Tempararily restricted	**267,498**	257,781
Permanently restricted - Investment in PLICO	**15,302,775**	15,302,775
Total net assets	**18,218,970**	18,159,456
Total liabilities and net assets	**$ 20,233,918**	$20,513,498

See accompanying notes.

at $59,514 net revenue over expenses. Please refer to the Report of the Committee on Audit and Appropriations for additional information.

2000 First Quarter Financial Statement

Attachment II is a copy of the Statement of Financial Position and Statement of Activities for the first quarter of 2000 for the Oklahoma State Medical Association. This provides an initial look at the Association's activities for the first part of the year. Overall, Total Gross Support and Revenue is $34,671 over the budgeted year-to-date numbers and Total Gross Expenses are $65,906 under budgeted gross expenses. The gross expenses are broken down further by noting that Total Supporting Services are $58,576 under budget, Council and Committee Expenses are $12,296 under budget, OSMA *Journal* Expenses are $4,067 under budget, and OSMA Annual Meeting Expenses are currently $12,397 under budget. Actual year-to-date net revenue over expenses is $105,188.

A more detailed look at the numbers indicate that our Total Investment Return is approximately $52,000 higher than budgeted (this is a tribute to the actions of the Committee on Finance, Personnel and Compensation). The Supplement from Operating Account and Supplement from Tort Reform Fund budgeted numbers are pending action by the House of Delegates. Salary and Benefit figures which are comprised of salaries, payroll taxes, pension plan, and health insurance are approximately $4,000 over budget; however, this is primarily due to a $6,473.76 payment to Utica Physicians' Association, Limited (UPAL) to properly fund the 1999 Staff Pension Plan. Office Supplies are $4,000 under budget. Equipment repairs and service are $2,000 over budget. Postage is $2,000 over budget and computer is $9,000 under budget. The remainder of the items are either very minimally off of budget projections or are a reflection of expense payment and accrual timing. The individual Council and Committee expenses which are off of the budgeted number reflect concentrations of the expenses either at the beginning or end of the year and are expected to stay on budget for the year. The Annual Meeting expenses which are under budget reflect, once again, a payment timing issue and are expected to stay on budget for the year.

As a whole, the first quarter numbers indicate that we are doing very well from the standpoint of both revenue and expenses, understanding that this is a snapshot at the first part of the year and actual numbers are expected to more closely approach budgeted numbers by year end.

The OSMA Education and Research Foundation is $131,447 revenue over expenses year-to-date. The Member Service For-Profit Corporation is $2,524 revenue over expenses year-to-date.

2000 OSMA Revised Annual Budget

Attachment III is the revised 2000 OSMA Budget (with attachments) for House approval. This budget reflects the changes approved by the Board of Trustees at its February meeting. Please refer to the Annual Report of the Board of Trustees for additional information regarding Board actions.

Recommendations

1. File 1999 OSMA annual audit for information.
2. File 1999 OSMA year-end financial statement for information.
3. Approval of 2000 OSMA revised annual budget as printed.
4. File 2000 OSMA first quarter financial statement for information.
5. Set 2001 dues for OSMA members at ~~$400~~ $300 per year.
6. Commend the Finance, Personnel, and Compensation Committee for their diligent work in investigating options and implementing a change in OSMA investment policy whereby OSMA investments have provided an improved return on our invested reserve funds and our operating funds.

Respectfully submitted,
Jack J. Beller, MD, Secretary-Treasurer

ATTACHMENT I

Report of Independent Auditors
Financial Statements
and Supplemental Information
Oklahoma State Medical Association

Years ended December 31, 1999 and 1998 with Report of Independent Auditors

Report of Independent Auditors
Board of Trustees
Oklahoma State Medical Association

We have audited the accompanying statements of financial position of Oklahoma State Medical Association (an Oklahoma corporation) as of December 31, 1999 and 1998, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Oklahoma State Medical Association, at December 31, 1999 and 1998, and the results of its operations and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States.

Ernst & Young, LLP
January 26, 2000

OSMA Statements of Activities

	December 31 1999	1998
Unrestricted Net Assets		
Support and revenues:		
Membership dues	$ 933,000	$ 1,043,229
Investment income	166,744	168,465
Advertising and sales - directary	60,447	75,761
Annuol meeting	70,210	72,476
Contracts with PLICO	387,500	387,500
Journal	154,065	94,952
Equity in earnings of uncansolidated subsidiary - MSC	8,075	20,000
Equity in losses af uncansalidated subsidiary - OCVO	(24,849)	
Other revenues and suppart	286,865	146,094
Total suppart and revenues	2,042,057	2,008,477
Expenses:		
Pragram services:		
Member services	691,157	724,216
Publications	154,045	139,203
Supporting services - general and administrative	1,147,058	843,027
Tatal expenses	1,992,260	1,706,446
Increase in unrestricted net assets	49,797	302,031
Temporarily Restricted Net Assets		
Investment income	10,717	10,371
Release af temporarily restricted net assets	(1,000)	
Increase in tempararily restricted net assets	9,717	10,371
Increase in net assets	59,514	312,402
Net assets at beginning af year	18,159,456	17,847,054
Net assets at end af yeor	$ 18,218,970	$18,159,456

See accampanying notes.

Oklahoma State Medical Association
Notes To Financial Statements
December 31, 1999

1. Basis of Presentation and Summary of Significant Accounting Policies

Basis of Presentation

The Oklahoma State Medical Association (the Association) was formed as a not-for-profit organization that provides educational and various other services to the members of the medical profession in the state of Oklahoma. Its wholly owned subsidiaries, Member Services Corporation (MSC) and Oklahoma Centralized Verification Organization, LLC (OCVO), provides other miscellaneous services to members of the Association.

The Association also owns 100% of the outstanding common stock of Physicians Liability Insurance Company (PLICO), which provides professional medical liability insurance and certain health and accident insurance to physicians who are members of the Association and to other qualified Oklahoma physicians. See Note 3.

The OSMA Education & Research Foundation (the Foundation) is a related not-for-profit organization that primarily provides referral services and financial assistance for members suffering from substance abuse disorders. The Foundation also provides for certain medical scholarship loans and grants. The Association's Board of Trustees are the sole voting members of the Foundation. The Association provides certain administrative services for the Foundation. Such services are not considered material to the Association.

Revenue Recognition

Membership dues are recognized ratably over the membership period.

Cash and Cash Equivalents

All highly liquid debt instruments with a maturity at purchase of three months or less and money market funds are considered to be cash equivalents.

OSMA Statements of Cash Flows

	December 31 1999	1998
Operating Activities		
Increase in net assets	$ 59,514	$ 312,402
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	90,845	88,804
Changes in operating assets and liabilities:		
Accounts receivable	398,904	(1,052,182)
Prepaid expenses	864	902
Equity in unconsolidated subsidiary - MSC	31,925	(20,000)
Losses of unconsolidated subsidiary - OCVO	24,849	
Accounts payable	(337,854)	1,040,965
Deferred membership dues	(1,842)	13,303
Net cash provided by operating activities	207,691	384,194
Investing Activities		
Purchase of investments	(3,241,208)	(195,908)
Proceeds from maturity of investments	2,792,521	274,640
Investment in OCVO	(165,000)	
Purchases of property and equipment	(36,987)	(53,029)
Net cash provided by (used in) investing activities	(650,674)	25,703
Net increase (decrease) in cash and cash equivalents	(383,469)	409,897
Cash and cash equivalents at beginning of year	1,514,333	1,104,436
Cash and cash equivalents at end of year	$ 1,130,864	$ 1,514,333

See accompanying notes.

Estimated Fair Value of Investments

	1999	1998
Mutual funds (includes equity and debt securities with various maturity dates)	$ 1,499,042	$ 156,183
U.S. Treasury Securities	—	1,044,172
Certificate of Deposit	150,000	—
	$ 1,649,042	$ 1,200,355

Investment income is composed of the following:

	1999	1998
Unrestricted assets		
Interest	$ 62,558	$ 76,261
Dividends	27,913	62,206
Capital gains	76,273	29,998
	$ 166,744	$ 168,465
Temparatily restricted assets		
Interest	$ 10,717	$ 10,371

Accounts Receivable and Accounts Payable

The Association bills and collects AMA dues from its members and remits dues received directly to the AMA. The AMA dues receivables are included in accounts receivable and amounts payable to the AMA are included in accounts payable.

Income Taxes

The Association was organized as a not-for-profit organization and, as such, is exempt from income taxes under Section 501(c)(6) of the Internal Revenue Code of 1986, as amended. The Association does, however, pay income taxes on unrelated business income, if any.

Property and Equipment

Depreciation is computed using the straight-line method over the estimated useful lives of the assets.

Investments

Investments are recorded at fair value at December 31, 1999 and 1998. See Note 2.

The Association accounts for its investment in PLICO using the cost method because neither the Association nor its Board of Trustees has a controlling interest in PLICO or is able to exercise significant influence over operating and financial policies of PLICO.

The Association accounts for its investment in MSC and OCVO using the equity method. The assets, liabilities, and results of operations of MSC and OCVO are not considered material to the Association and therefore are not consolidated.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires the Association to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

2. Investments

Statement of Financial Accounting Standards No. 124, *Accounting for Certain Investments Held by Not-for-Profit Organizations*, requires that all investments in debt and equity securities be reported at fair value with gains and losses included in the statements of activities. At December 31, 1999 and 1998, the Association carried its investments in debt and equity securities at fair value in accordance with FAS 124.

The estimated fair value of investments by class at December 31, 1999 and 1998, are as shown (see left).

3. Investment in PLICO

PLICO was formed to provide professional medical liability insurance and certain health and accident insurance to physicians who are members of the Association and to other qualified Oklahoma physicians. The business affairs of PLICO are managed by a Board of Directors that is not controlled by the Association or its Board of Trustees. PLICO is domiciled in Oklahoma and is subject to regulatory oversight by the Oklahoma Insurance Department (the Department). The financial statements of PLICO are prepared in

conformity with the accounting practices prescribed or permitted by the Department (statutory accounting practices), which is a comprehensive basis of accounting other than generally accepted accounting principles (GAAP).

The primary source of capital for PLICO has been through periodic assessments of members by the Association. Statement of Financial Accounting Standards No. 117, *Financial Statements of Not-for-Profit Organizations*, requires not-for-profit organizations like the Association to report the amounts for each of three classes of net assets—permanently restricted net assets, temporarily restricted net assets, and unrestricted net assets—based on the existence or absence of donor-imposed restrictions. Although the assessments were involuntary and therefore cannot contain donor-imposed restrictions, the Association has accounted for the assessments as permanently restricted because such assessments were intended to provide PLICO with permanent capital.

PLICO uses independent consulting actuaries to review its evaluation of the required level of reserves for losses and loss adjustment expenses. The consulting actuaries determined a low reasonable estimate and a high reasonable estimate for PLICO's professional medical liability loss and loss adjustment expense reserves. These estimated discounted net reserves ranged from $77,847,000 to $135,295,000 at December 31, 1999, and from $77,180,000 to $130,123,000 at December 31, 1998. PLICO's discounted net reserves for professional medical liability losses and loss adjustment expenses, plus capital and surplus in excess of the $4,000,000 statutory minimum were approximately $108,124,000 and $106,185,000 at December 31, 1999 and 1998, respectively, and were within the consulting actuaries' recommended ranges. In addition, the recorded reserves were in compliance with the levels permitted by the Department (see right). However, the recorded reserves without regards to the permitted practice described below were approximately $96,919,000 and $94,343,000 at December 31, 1999 and 1998, respectively, which is below the mid-point of the estimated discounted reserve range. To the extent actual loss experience develops higher than the recorded amount, PLICO would need to take immediate action to increase reserves and capital and surplus. Under similar historical circumstances, PLICO has increased reserves and maintained capital and surplus through premium increases and/or special assessments of members by the Association.

Summarized Financial Information for PLICO on a GAAP Basis

	1999	1998
	(In Thousands)	
Cash and invested assets	$ 117,162	$123,429
Reinsurance balances	56,073	57,966
Other assets	3,530	6,121
Total assets	$ 175,765	$187,516
Liability for losses and loss adjustment expenses	157,176	$156,658
Advance premiums	8,479	11,573
Other liabilities	19	92
Total liabilities	165,674	168,323
Stockholders' equity	11,091	19,193
Total liabilities and stockholders' equity	$ 176,765	$187,516
Premiums earned	$ 49,697	$ 51,819
Losses and loss adjustment expenses incurred	(47,352)	(49,778)
Other underwriting expenses	(9,987)	(9,994)
Net investment income	6,993	8,378
Federal income tax benefit	12	360
Net income (loss)	$ (637)	$ 785

PLICO received written approval from the Department to report a prescribed level of discounted loss and loss adjustment expense reserves which is below the mid-point of PLICO's consulting actuaries' range (see above). This agreement with the Department states that PLICO would record discounted net professional medical liability reserves plus capital and surplus in excess of the $4,000,000 statutory minimum at a level that is at least at the 50th percentile of the consulting actuaries' range of discounted reserves. PLICO met these requirements at December 31, 1999 and 1998. The Board of Directors of PLICO currently intends to maintain reserves for losses and loss adjustment expenses at a level that is at least at the 50th percentile of the consulting actuaries' discounted reserve range level permitted by the Department which the Board of Directors of PLICO believes is consistent with the not-for-profit philosophy of PLICO and the not-for-profit objectives of the Association.

The reserves for unpaid losses and loss adjustment expenses are estimated using case-basis valuations and statistical analyses and represent the estimated ultimate net cost of all reported and unreported losses incurred during the year. Among the factors considered in determining the liability are cumulative payments made on losses and loss adjustment expenses by accident year, PLICO's case-basis estimates of the remaining liability for losses and loss adjustment expenses on reported claims, and an estimate for claims incurred but not reported (IBNR) and development of case-basis estimates. These estimates are subject to the effects of trends in loss severity and frequency. Although considerable variability is inherent in such estimates, the Board of Directors of PLICO believes that the reserves for losses and loss adjustment expenses are adequate. The estimates are continually reviewed and adjusted as necessary as experience develops or new information becomes known; such adjustments are included in PLICO's current operations.

The most reasonable estimate of a liability for unpaid losses and loss adjustment expenses is made when: 1) the period of time between the loss occurrence and ultimate settlement is short; 2) the absolute number of policies is high, resulting in more meaningful average cost amounts; and 3) a large base of historical data exists. Because of the length of time required for the development of the ultimate liability and PLICO's small policy base, there is a significant degree of uncertainty in PLICO's reserve estimates. Accordingly, the ultimate settlement of losses and loss adjustment expenses may vary significantly from the estimated amounts included in PLICO's statutory-basis financial statements.

Schedule of Revenues and Expenses

	Budget	Actual
		(Unaudited)
Suppart and revenues by budget categary:		
Membership dues	$ 1,084,860	$ 933,000
Cammissians and interest	210,000	229,122
Advertising and sales-directary	70,000	60,447
Cantracts with PLICO	337,500	387,500
Lease incame	37,200	36,500
Journal	175,420	154,065
Annual meeting	92,500	70,210
Other	164,500	180,930
Tatal suppart and revenues	2,171,980	2,051,774
Expenses by budget categary:		
Member services:		
Annual meeting	75,850	74,534
Councils and cammittees	405,200	394,316
Other	374,900	222,307
	855,950	691,157
Publicatians	162,550	154,045
General and administrative	1,145,600	1,147,058
Tatal expenses	2,164,100	1,992,260
Increase in net assets	$ 7,880	$ 59,514

Schedule of General and Administrative Expenses by Type

	Budget	Actual
		(Unaudited)
Salaries	$ 565,000	$ 567,697
Payroll taxes	45,000	43,824
Pensian plan cantributian	50,000	31,367
Health insurance	65,000	67,106
Staff and afficers	79,500	78,224
Disability incame insurance	3,600	3,082
Office supplies	40,000	46,285
Equipment repairs and service	7,500	11,755
General insurance	30,000	21,720
Utilities	22,000	22,388
Building maintenance, remadeling, and yard maintenance	23,000	29,738
Accaunting and legal	37,000	67,362
Camputer and camputer upgrade	90,000	56,845
Dues and subscriptians	5,000	3,391
Depreciatian	80,000	90,845
Other	3,000	5,429
	$ 1,145,600	$1,147,058

At periodic intervals, the Department routinely examines PLICO's statutory-basis financial statements as part of their legally prescribed oversight of the insurance industry. Based on these examinations, the regulators can direct that PLICO's statutory-basis financial statements be adjusted in accordance with their findings. The Department completed its most recent triennial examination of PLICO's statutory-basis financial statements for the period ended December 31, 1995. The Department is currently conducting a regular triennial examination of its December 31, 1998 statutory-basis financial statements.

The following is unaudited summarized financial information for PLICO on a GAAP basis as of and for the years ended December 31, 1999 and 1998 (see previous page).

PLICO paid the Association $387,500 in 1999 and 1998, for services to control liability losses through research and promotion of good medical practices. These amounts have been included as revenues by the Association.

4. Investment in OCVO

In 1996 and 1997, the Association expensed a $50,000 investment in the Oklahoma Centralized Verification Organization (OCVO). The OCVO was established to provide efficient and effective credentialing of physicians and allied health professionals statewide to hospitals, group practices, insurers, managed care organizations, and others. In 1998, the Association recognized approximately $7,000 of income related to a profit sharing arrangement with the OCVO.

Effective January 1, 1999, the Association purchased the assets of the OCVO for a purchase price of $65,000. Subsequent to the initial purchase, the Association contributed an additional $100,000 to the OCVO.

5. Employee Benefit Plans

The Association sponsors a defined contribution plan that covers substantially all full-time employees. Contributions to the plan are at the discretion of the Association. Expense relating to this plan was approximately $31,000 and $22,000 in 1999 and 1998, respectively.

6. Year 2000 (unaudited)

In prior years, the Company discussed the nature and progress of its plans to become Year 2000 ready. In late 1999, the Company completed its remediation and testing of systems. As a result of those planning and implementation efforts, the Company experienced no significant disruptions in mission critical information technology and non-information technology systems and believes those systems successfully responded to the Year 2000 date change. The Company is not aware of any material problems resulting from Year 2000 issues, either with its products, its internal systems, or the products and services of third parties. The Company will continue to monitor its mission critical computer applications and those of its suppliers and vendors throughout the year 2000 to ensure that any latent Year 2000 matters that may arise are addressed promptly.

Report of Independent Auditors on Supplemental Information

Board of Trustees
Oklahoma State Medical Association

Our audit was conducted for the purpose of forming an opinion on the basic financial statements taken as a whole. The Schedule of Revenues and Expenses and Schedule of General and Administrative Expenses by Type are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information, except for that portion marked "unaudited," on which we express no opinion, has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Ernst & Young, LLP
January 26, 2000

ATTACHMENT II

Statement of Financial Position and Statement of Activities

OSMA Statement of Financial Position 3/31/2000

	Balance 03/31/00	Balance 03/31/99
Assets:		
Current Assets		
Operoting Account	945,647	0
Cosh ond Cosh Equivolents	29,624	1,623,180
Investments	485	1,382,235
Short Term Reserve	253,311	0
Long Term Reserve	1,857,044	0
Accounts Receivoble	215,693	425,336
Prepoid Expenses	14,403	15,267
Totol Current Assets	3,316,207	3,446,019
Property ond Equipment:		
Lond	7,808	7,808
Building ond Improvements	494,322	494,322
Furniture, Fixtures ond Equipment	621,493	584,506
	1,123,622	1,086,636
Less: Accumuloted Depreciotion & Amortizotion	(586,392)	(495,547)
Totol Property ond Equipment	537,231	591,089
Other Investments:		
Investment OSMA MBR Services Corporotion	12,978	24,903
Investment in Subsidiory - PLICO	15,302,775	15,302,775
Investment - OCVO	140,752	0
Totol Other Investments	15,456,505	15,327,678
Totol Assets	19,309,943	19,364,785

Liobilities ond Net Assests

	Balance 03/31/00	Balance 03/31/99
Liobilities:		
Current Lioblities		
Accounts Poyoble	133,885	370,218
Deferred Membership Dues	858,065	864,175
Student Fund - Loon & Scholorship Fund	0	1,174
Totol Current Liobilities	991,950	1,235,567
Long Term Liobilities	—	—
Totol Liobilities	991,950	1,235,567
Net Assets:		
Unrestricted		
Unrestricted Net Assets	2,186,724	2,110,519
Prior Period-PLICO	500,000	500,000
Increose in Unrestricted	100,024	(13,545)
Totol Unrestricted	2,786,747	2,596,973
Tempororily Restricted		
Tempororily Restricted-Leebron Memoriol	3,778	4,278
Tempororily Restricted - Loon & School	91,819	91,819
Tempororily Restricted - Tort Reform	126,927	126,927
Tempororily Restricted - Johnson	5,946	6,446
Totol Tempororily Restricted	228,470	229,470
Permonently Restricted Net Assets	15,302,775	15,302,775
Total Net Assets	18,317,992	18,129,218
Totol Liobilities ond Net Assets	19,309,943	19,364,785

OSMA Statement of Activities

	Monthly Actual	% of Gross Revenue	Monthly Budget	% of Budget
Support and Revenue				
OSMA Membership Dues	83,168	37%	81,688	102%
Total Investment Return	94,325	42%	21,277	443%
AMA Commissions	13,966	6%	4,167	335%
Building Lease	2,400	1%	3,100	77%
Directory Sales and Advertising	0	0%	0	0%
Computer Label Sales	727	0%	833	87%
Medical Education Council	0	0%	904	0%
Member Service For-Profit Corporation	0	0%	417	0%
Member Service Council	0	0%	117	0%
Contract with Subsidiary - PLICO	0	0%	28,125	0%
PLICO/OCVO Support	0	0%	0	0%
Supplement from Operating Account	0	0%	12,822	0%
Supplement from Tort Reform Fund	0	0%	4,383	0%
OSMA-ERF Administrative Support Fee	0	0%	1,250	0%
Other Revenue	0	0%	167	0%
Total Support and Revenue	194,585	88%	159,250	122%
Subscription	90	0%	250	36%
OSMA Dues Allocation	9,423	4%	9,423	100%
Advertising	1,324	1%	3,333	40%
Total *Journal* Support and Revenue	10,836	5%	13,006	83%
Exhibit Fees	(1,000)	0%	833	-120%
OSMA Dues Allocation	2,750	1%	2,750	100%
Annual Meeting Sponsorships	0	0%	1,833	0%
Ticket Sales	255	0%	1,156	22%
Total Annual Meeting Support & Revenue	2,005	1%	6,572	31%
Directory Sales	14,170	6%	5,083	279%
Directory Advertising	565	0%	2,167	26%
Total Directory Support & Revenue	14,735	7%	7,250	203%
Total Gross Support & Revenue	222,161	100%	186,078	119%
		% of Gross Expenses		
Council and Committee Expenses				
Professional Communications	5,401	5%	2,308	234%
Public Relations	94	0%	4,458	2%
Planning & Development Council	0	0%	167	0%
Continuing Medical Education	148	0%	780	19%
Medical Services Council	0	0%	417	0%
Member Services Council	(834)	1%	83	-999%
Public and Mental Health	709	1%	1,292	55%
Council on State Legislation	13,959	12%	12,833	109%
OMPAC	(1,331)	1%	983	-135%
Governmental Activities	2,103	2%	3,333	63%
Organized Medical Staffs	0	0%	221	0%
Alliance Activities	66	0%	1,823	4%
Student Activities	0	0%	1,125	0%
Resident Activities	0	0%	125	0%
Rural Health	0	0%	208	0%
Young Physician Section	0	0%	417	0%
10% Contingency	0	0%	2,083	0%
Medical Ethics & Competency	0	0%	83	0%
International Medical Graduates	48	0%	221	22%
Membership Recruitment	100	0%	395	25%
Physicians Campaign for a Healthier OK	8,380	7%	7,408	113%
Total Council and Committee Expenses	28,842	24%	40,763	71%

OSMA Statement of Activities

Actual YTD	% of Gross Revenue	Budget YTD	% of YTD Budget	Actual YTD 1999	% of YTD Gross
249,111	42%	245,064	102%	250,751	38%
115,723	20%	63,831	181%	11,615	2%
35,259	6%	12,501	282%	35,590	5%
9,300	2%	9,300	100%	11,700	2%
0	0%	0	0%	35,198	5%
2,383	0%	2,499	95%	2,449	0%
3,200	1%	2,712	118%	0	0%
0	0%	1,251	0%	0	0%
1,400	0%	351	399%	9,685	1%
84,375	14%	84,375	100%	134,375	20%
0	0%	0	0%	100,000	15%
0	0%	38,466	0%	0	0%
0	0%	13,149	0%	0	0%
0	0%	3,750	0%	0	0%
0	0%	501	0%	0	0%
500,752	84%	477,750	105%	591,363	89%
690	0%	750	92%	240	0%
28,268	5%	28,269	100%	28,605	4%
8,405	1%	9,999	84%	14,975	2%
37,363	6%	39,018	96%	43,820	7%
5,090	1%	2,499	204%	12,600	2%
8,250	1%	8,250	100%	7,500	1%
1,000	0%	5,499	18%	3,000	0%
255	0%	3,468	7%	6,390	1%
14,595	2%	19,716	74%	29,490	4%
38,501	6%	15,249	252%	0	0%
1,695	0%	6,501	26%	0	0%
40,196	7%	21,750	185%	0	0%
592,905	100%	558,234	106%	664,673	100%
	% of Gross Expenses				**% of YTD Expenses**
8,352	2%	6,924	121%	29,990	4%
1,815	0%	13,374	14%	1,551	0%
0	0%	501	0%	2,947	0%
4,751	1%	2,340	203%	0	0%
125	0%	1,251	10%	695	0%
1,549	0%	249	622%	10,869	2%
1,076	0%	3,876	28%	4,156	1%
35,039	7%	38,499	91%	38,973	6%
2,605	1%	2,949	88%	867	0%
6,308	1%	9,999	63%	6,927	1%
0	0%	663	0%	56	0%
4,175	1%	5,469	76%	3,162	0%
0	0%	3,375	0%	5,063	1%
0	0%	375	0%	0	0%
0	0%	624	0%	235	0%
0	0%	1,251	0%	0	0%
2,932	1%	6,249	47%	10,674	2%
0	0%	249	0%	0	0%
48	0%	663	7%	49	0%
578	0%	1,185	49%	0	0%
40,641	8%	22,224	183%	0	0%
109,993	23%	122,289	90%	116,215	17%

OSMA Statement of Activities *(continued)*

	Monthly Actual	% of Gross Expenses	Monthly Budget	% of Budget
OSMA *Journal* Expenses				
Printing	1,071	1%	8,042	13%
Journal Management Contract	0	0%	750	0%
Journal Editars Fees	500	0%	633	79%
Journal Cantract Services	981	1%	500	196%
Journal Praductian	0	0%	625	0%
Journal Postage Mailing Hause	0	0%	667	0%
Operating	70	0%	417	17%
Tatal Journal Expenses	2,621	2%	11,634	23%
OSMA Annual Meeting Expenses				
Exhibits	0	0%	333	0%
Phatas	0	0%	108	0%
Planning	12	0%	17	70%
Printing	940	1%	917	102%
Supplies	0	0%	570	0%
Entertainment/Speakers	0	0%	0	0%
Entertainment	0	0%	375	0%
Signs/Security	0	0%	83	0%
Audia Visual	0	0%	500	0%
Awards/Traphies	0	0%	250	0%
Hatel/Canventian	0	0%	1,858	0%
Flawers	0	0%	75	0%
Tatal Annual Meeting Expenses	951	1%	5,086	19%
Directary Printing/Mailing	0	0%	1,500	0%
Total Gross Expenses	118,204	100%	184,541	64%
Net Income	103,792		79	999%
Supporting Services				
Salaries	51,270	43%	55,000	93%
Payrall Taxes	4,200	4%	4,250	99%
Pensian Plan	9,745	8%	4,167	234%
Health Insurance	(417)	0%	6,083	-7%
Staff Travel	(91)	0%	1,265	-7%
Officer Travel	0	0%	883	0%
Officer Stipends	1,000	1%	4,667	21%
Staff/Officers Miscellaneaus	74	0%	833	9%
Executive Cammittee/Baard af Trustees	430	0%	833	52%
Disability & Life Insurance	1,085	1%	542	200%
Office Supplies	755	1%	4,167	18%
Equipment Repairs and Service	3,460	3%	1,417	244%
Pastage	0	0%	3,333	0%
Telephane	969	1%	1,667	58%
General Insurance	0	0%	2,083	0%
Utilities	1,487	1%	1,833	81%
Services	1,518	1%	833	182%
Building Maintenance and Repairs	2,443	2%	1,250	195%
Yard Maintenance	486	0%	667	73%
Accaunting	102	0%	1,000	10%
Legal	3,863	3%	4,167	93%
Camputer	2,407	2%	6,542	37%
Camputer Upgrade	0	0%	0	0%
Dues & Subscriptians	200	0%	600	33%
Awards and Cantributians	23	0%	417	6%
Caunty Saciety Dues Cammissian	704	1%	2,083	34%
AMA Canventian	0	0%	7,892	0%
Depreciatian Expense	0	0%	6,667	0%
Trustee Fees OSMA Reserves	0	0%	0	0%
Caalitian far Quality Patient Care, Inc.	0	0%	0	0%
OCVO Funding	0	0%	0	0%
Other Operating	75	0%	417	18%
Total Supporting Services	85,790	73%	125,558	68%

OSMA Statement of Activities

Actual YTD	% of Gross Expenses	Budget YTD	% of YTD Budget	Actual YTD 1999	% of YTD Expenses
19,500	4%	24,126	81%	24,919	4%
6,000	1%	2,250	267%	9,000	1%
1,500	0%	1,899	79%	0	0%
1,129	0%	1,500	75%	794	0%
280	0%	1,875	15%	0	0%
2,200	0%	2,001	110%	4,284	1%
226	0%	1,251	18%	2,857	0%
30,835	6%	34,902	88%	41,854	6%
0	0%	999	0%	0	0%
0	0%	324	0%	0	0%
12	0%	51	23%	85	0%
940	0%	2,751	34%	6,074	1%
1,910	0%	1,710	112%	2,694	0%
0	0%	0	0%	2,070	0%
0	0%	1,125	0%	0	0%
0	0%	249	0%	0	0%
0	0%	1,500	0%	0	0%
0	0%	750	0%	308	0%
0	0%	5,574	0%	367	0%
0	0%	225	0%	0	0%
2,861	1%	15,258	19%	11,598	2%
25,930	5%	4,500	576%	0	0%
487,717	100%	553,623	88%	678,218	100%
100,024		237	999%	(13,545)	
161,135	33%	165,000	98%	133,861	20%
14,081	3%	12,750	110%	11,800	2%
16,331	3%	12,501	131%	12,718	2%
22,021	5%	18,249	121%	16,849	2%
2,204	0%	3,795	58%	4,162	1%
703	0%	2,649	27%	947	0%
15,000	3%	14,001	107%	9,000	1%
630	0%	2,499	25%	6,455	1%
1,344	0%	2,499	54%	479	0%
2,603	1%	1,626	160%	700	0%
8,007	2%	12,501	64%	12,927	2%
6,132	1%	4,251	144%	4,681	1%
11,815	2%	9,999	118%	10,742	2%
3,804	1%	5,001	76%	5,096	1%
0	0%	6,249	0%	526	0%
3,549	1%	5,499	65%	4,543	1%
4,476	1%	2,499	179%	1,567	0%
4,896	1%	3,750	131%	5,032	1%
1,569	0%	2,001	78%	973	0%
9,305	2%	3,000	310%	8,545	1%
11,361	2%	12,501	91%	12,146	2%
10,176	2%	19,626	52%	15,984	2%
0	0%	0	0%	4,698	1%
1,911	0%	1,800	106%	1,456	0%
3,078	1%	1,251	246%	2,596	0%
4,138	1%	6,249	66%	8,616	1%
(2,182)	0%	23,676	-9%	(7,836)	1%
0	0%	20,001	0%	0	0%
0	0%	0	0%	877	0%
0	0%	0	0%	50,000	7%
0	0%	0	0%	165,601	24%
11	0%	1,251	1%	2,811	0%
318,098	65%	376,674	84%	508,550	75%

Education & Research Foundation, MidFirst Bank Jan. 1, 2000-Mar. 31, 2000		
Checking Accaunt #1801002376 Bolonce		$ 11,575
Savings Accaunt #1801002384 Balonce		162,318
Tatal Beginning Balance 1/1/00		$ 173,893
	Revenue	**Expenses**
Foundation		
Bank Interest Less Charges	$ 2,582	
Restricted		
Grants:		
Chest Faundatian	10,000	
American Medical Associotion		360
Catering		53
		413
Physician Recavery Progrom		
PLICO	125,000	
Dental Assac. Contributian	3,000	
Osteapathic Assoc. Cantribution	3,000	
Colarada Pers. Edu.(99 loan reimb.)	5,000	
Misc.	120	
	136,120	
Directar's Cantract		23,000
Assistant Directar's Contracts		8,425
Renassiance Hatel (sponsorship)		500
		31,925
Continuing Medicol Educatian		
PLICO Grant	50,000	
Lass Preventian Seminars		18,298
Cantinuing Medical Educatian		16,619
		34,917
Total Revenue	198,702	
Total Expenses		67,255
YTD Revenue over Expenses		$131,447

Total 1999/2000 Restricted Grants/Funds:	
Chest Foundatian	$10,000
Chest Foundatian	2,500
Lambird	500
Tatal	$13,000

Member Service For-Profit Corporation, Bank of America Jan. 1, 2000-Mar. 31, 2000		
Checking Account #194743 Bolonce		$ 875
Savings Accaunt #194581 Balance		12,103
Tatal Beginning Balance 1/1/00		$ 12,978
	Revenue	**Expenses**
Revenue		
C.L. Frates	$ 1,500	
I.C. Systems	516	
Auto Flex	200	
Intermedia	232	
	2,448	
Interest less bank charges:	$ 76	
Expenses		0
Total Revenue	2,524	
Total Expenses		0
YTD Revenue over Expenses	$ 2,524	

OSMA Statement of Activities 03/31/00					
	Actual Current Month	Actual 2000 YTD	Actual 1999 YTD	Total 2000 Budget	Actual 1999 Year End
Support ond Revenue					
OSMA Membership Dues	83,168	249,111	250,751	980,259	933,000
Total Investment Return	94,325	115,723	11,615	255,325	117,461
AMA Commissions	13,966	35,259	35,590	50,000	51,659
Building Leose	2,400	9,300	11,700	37,200	36,500
Directory Sales and Advertising	0	0	35,198	0	60,447
Medical Educatian Cauncil	0	3,200	0	10,850	0
Camputer Label Sales	727	2,383	2,449	10,000	7,950
Member Service Far-Prafit Carparatian	0	0	0	5,000	8,075
Change in OCVO Equity	0	0	0	0	(24,849)
Member Service Council	0	1,400	9,685	1,400	15,115
Membership Recruitment	0	0	0	0	25,000
Contract with Subsidiary - PLICO	0	84,375	134,375	337,500	387,500
PLICO/OCVO Suppart	0	0	100,000	0	100,000
Supplement fram Operating Accaunt	0	0	0	153,859	0
Supplement from Tort Reform Fund	0	0	0	52,600	0
OSMA-ERF Administrative Support Fee	0	0	0	15,000	0
Other Revenue	0	0	0	2,000	3,896
Totol Support and Revenue	194,585	500,752	591,363	1,910,993	1,781,753
Subscriptian	90	690	240	3,000	1,443
OSMA Dues Allocatian	9,423	28,268	28,605	113,070	114,420
Advertising	1,324	8,405	14,975	40,000	38,202
Totol *Journal* Support ond Revenue	10,836	37,363	43,820	156,070	154,065
Exhibit Fees	(1,000)	5,090	12,600	10,000	23,710
OSMA Dues Allocatian	2,750	8,250	7,500	33,000	30,000
Spansarships	0	1,000	3,000	22,000	5,530
Ticket Sales	255	255	6,390	13,875	10,970
Totol Annuol Meeting Support & Revenue	2,005	14,595	29,490	78,875	70,210
Directory Soles	14,170	38,501	0	61,001	0
Directory Advertising	565	1,695	0	26,000	0
Totol Directory Support & Revenue	14,735	40,196	0	87,000	0
Totol Gross Support ond Revenue	222,161	592,905	664,673	2,232,938	2,006,027
Supporting Services					
Salaries	51,270	161,135	133,861	660,000	567,697
Payrall Taxes	4,200	14,081	11,800	51,000	43,824
Pensian Plan	9,745	16,331	12,718	50,000	31,367
Health Insurance	(417)	22,021	16,849	73,000	67,106
Staff Trovel	(91)	2,204	4,162	15,175	14,434
Officer Travel	0	703	947	10,600	8,818
Officer Stipends	1,000	15,000	9,000	56,000	41,000
Staff/Officer Miscellaneaus	74	630	6,455	10,000	9,304
Executive Committee/Board of Trustees	430	1,344	479	10,000	4,668
Disability Insurance	1,085	2,603	700	6,500	3,082
Office Supplies	755	8,007	12,927	50,000	46,285
Equipment Repairs and Service	3,460	6,132	4,681	17,000	11,755
Postage	0	11,815	10,742	40,000	26,638
Telephone	969	3,804	5,096	20,000	19,901
General Insurance	0	0	526	25,000	21,720
Utilities	1,487	3,549	4,543	22,000	22,388
Services	1,518	4,476	1,567	10,000	3,025
Building Maintenance ond Repairs	2,443	4,896	5,032	15,000	23,662
Yord Maintenance	486	1,569	973	8,000	6,076
Accounting	102	9,305	8,545	12,000	9,990
Legal	3,863	11,361	12,146	50,000	57,372
Camputer	2,407	10,176	15,984	78,500	56,845
Computer Upgrade	0	0	4,698	0	0
Dues & Subscriptions	200	1,911	1,456	7,200	3,391
Awords and Cantributians	23	3,078	2,596	5,000	3,143

OSMA Statement of Activities 03/31/00 (continued)

	Actual Current Month	Actual 2000 YTD	Actual 1999 YTD	Total 2000 Budget	Actual 1999 Year End
Supporting Services *(continued)*					
County Society Dues Commission	704	4,138	8,616	25,000	21,867
AMA Convention	0	(2,182)	(7,836)	94,700	93,614
Depreciation Expense	0	0	0	80,000	90,844
Trustee Fees OSMA Reserves	0	0	877	0	4,120
Coalition for Quality Patient Care, Inc.	0	0	50,000	0	50,000
OCVO Funding	0	0	165,601	0	0
Other Operating	75	11	2,811	5,000	5,432
Total Supporting Services	85,790	318,098	508,550	1,506,675	1,369,364
Council and Committee Expenses					
Professional Communications	5,401	8,352	29,990	27,700	47,990
Public Relations	94	1,815	1,551	53,500	8,423
Planning & Development Council	0	0	2,947	2,000	7,085
Continuing Medical Education	148	4,751	0	9,363	0
Medical Services Council	0	125	695	5,000	4,433
Member Services Council	(834)	1,549	10,869	1,000	20,464
Public and Mental Health	709	1,076	4,156	15,500	50,817
Council on State Legislation	13,959	35,039	38,973	154,000	136,496
OMPAC	(1,331)	2,605	867	11,800	5,156
Governmental Activities	2,103	6,308	6,927	40,000	36,867
Organized Medical Staffs	0	0	56	2,650	4,335
Alliance Activities	66	4,175	3,162	21,875	11,096
Student Activities	0	0	5,063	13,500	7,134
Resident Activities	0	0	0	1,500	0
Rural Health	0	0	235	2,500	235
Young Physician Section	0	0	0	5,000	1,601
10% Contingency	0	2,932	10,674	25,000	27,085
Medical Ethics & Competency	0	0	0	1,000	45
International Medical Graduates	48	48	49	2,650	1,637
Membership Recruitment	100	578	0	4,740	23,419
Physicians Campaign for a Healthier OK	8,380	40,641	0	88,900	0
Total Council and Committee Expenses	28,842	109,993	116,215	489,178	394,316
OSMA *Journal* Expenses					
Printing	1,071	19,500	24,919	96,500	95,546
Journal Management Contract	0	6,000	9,000	9,000	36,000
Journal Editors Fees	500	1,500	0	7,600	6,400
Journal Contract Services	981	1,129	794	6,000	4,717
Journal Production	0	280	0	7,500	30
Journal Postage/Mailing House	0	2,200	4,284	8,000	8,398
Operating	70	226	2,857	5,000	2,954
Total *Journal* Expenses	2,621	30,835	41,854	139,600	154,045
OSMA Annual Meeting Expenses					
Exhibits	0	0	0	4,000	1,511
Photos	0	0	0	1,300	986
Planning	12	12	85	200	172
Printing	940	940	6,074	11,000	11,091
Supplies	0	1,910	2,694	6,845	2,914
Entertainment/Speakers	0	0	2,070	0	4,122
Entertainment	0	0	0	4,500	0
Lunches	0	0	0	0	163
Signs/Security	0	0	0	1,000	739
Audio Visual	0	0	0	6,000	5,150
Awards/Trophies	0	0	308	3,000	3,174
Dinner for Executive Committee/Guests	0	0	0	0	750
Hotel/Convention	0	0	367	22,300	43,761
Flowers	0	0	0	900	0
Total Annual Meeting Expenses	951	2,861	11,598	61,045	74,534
Directory Printing/Mailing	0	25,930	0	18,000	0
Total Gross Expenses	118,204	487,717	678,218	2,214,498	1,992,259
Net Income	103,792	100,024	(13,545)	940	13,769

ATTACHMENT III

OSMA 2000 Proposed Budget

	12/31/98 Year-End	12/31/99 Year-End	% of 1999 Budget	1999 Budget	2000 Proposed Budget
Support and Revenue					
Membership					
OSMA Dues	1,043,229	933,000	86%	1,084,860	980,259
Total Investment Return	178,836	180,977	113%	160,000	255,325
AMA Commissions	52,235	51,659	103 %	50,000	50,000
Building Leases	34,800	36,500	98%	37,200	37,200
Computer Labels	7,428	7,950	106%	7,500	10,000
Member Service For-Profit Corp.	20,000	20,000	133%	15,000	5,000
Member Services Council	21,925	15,115	76%	20,000	1,400
Council on Medicol Educotion (13)	3,063	6,200	151%	4,100	10,850
PLICO Royolty	387,500	387,500	115%	337,500	337,500
PLICO/OCVO Support	—	100,000	100%	100,000	—
Miscelloneous Sponsorships	—	0	0	20,000	—
Supplement from Operoting Account	—	—	—	—	153,859
Supplement from Tort Reform Fund	—	—	—		52,600
OSMA-ERF Administrotive, Support Fee	—	—	—	—	15,000*
Other Revenue	29,707	3,896	195%	2,000	2,000
Total Membership Suppart & Revenue	$1,749,242	$1,742,797	95%	$1,838,160	$1,910,993
Directary	$75,761	60,447	86%	70,000	—
Advertising	—	—	—	—	26,000
Soles	—	—	—	—	61,000
Tatal Directary Support & Revenue	$75,761	$60,447	86%	$70,000	87,000
***Journal* (1)**					
Subscriptions	$5,162	$1,443	144%	$1,000	$3,000
Dues Allocotion	60,000	114,420	100%	114,420	113,070
Advertising	29,790	38,202	64%	60,000	40,000
Tatal *Journal* Suppart & Revenue	$94,952	$154,065	88%	$175,420	$156,070
Annual Meeting (2)					
Exhibit Fees	32,251	23,710	59%	40,000	10,000
Dues Allocotion	30,000	30,000	100%	30,000	33,000
Sponsorships	—	5,530	55%	10,000	22,000
Ticket Soles	10,225	10,970	88%	12,500	13,875
Tatal Annual Meeting Suppart & Revenue	$72,476	$70,210	76%	$92,500	$78,875
Tatal Support & Revenue	$1,992,431	$2,027,519	93%	$2,176,080	$2,232,938
Pragram Services					
Directary Expenses					
Printing/binding/moiling	—	—	—	—	18,000
***Journal* Expenses (1)**					
Monogement Controct	—	36,000	100%	36,000	9,000
Printing	89,665	95,546	96%	100,000	96,500
Art Work	5,061	—	—	—	—
Proofreoding	486	—	—	—	—
Editor Fees	—	6,400	84%	7,600	7,600
Controct Services	—	4,717	105%	4,500	6,000
Production Expenses	—	—	—	5,000	7,500
Postoge/Moiling House	—	8,398	149%	6,000	8,000
Operoting	43,991	2,984	86%	3,450	5,000
Total *Journal* Pragram Services	$139,203	$154,045	95%	$162,550	$139,600
Annual Meeting Expenses (Totals) (2)	$63,975	$74,534	98%	$75,850	$78,545

*To be used to offset Stoff support of Foundation activities

OSMA 2000 Proposed Budget *(continued)*

	12/31/98 Year-End	12/31/99 Year-End	% of 1999 Budget	1999 Budget	2000 Proposed Budget
Program Services (continued)					
Council/Committee Expenses					
Professional Communications (3)	102,901	47,990	120%	40,000	27,700
Public Relations (4)	—	$8,423	56%	$15,000	$53,500
Planning & Development	1,948	7,085	236%	3,000	2,000
Medical Services	820	4,433	148%	3,000	5,000
Member Services	17,389	20,464	102%	20,000	1,000
Public & Mental Health (5)	2,864	50,817	96%	53,000	15,500
State Legislation (6)	147,474	136,496	100%	136,650	154,000
OMPAC (7)	8,487	5,156	48%	10,800	11,800
Governmental Activities (8)	30,259	36,867	92%	40,000	40,000
Organized Medical Staff Section	1,651	4,335	108%	4,000	2,650
OSMA Alliance (9)	10,402	11,096	111%	10,000	21,875
Medical Student Section (10)	6,110	7,134	59%	12,000	13,500
Resident Physician Section	0	0	0	1,000	1,500
International Medical Graduates	1,788	1,637	60%	2,750	2,650
Medical Ethics & Competency	0	45	4%	1,000	1,000
Membership Task Force (11)	—	—	—	—	4,740
Physicians' Campaign for a Healthier Oklahoma (12)	—	—	—	—	88,900
Council on Rural Health	300	235	12%	2,000	2,500
Young Physicians Section	0	1,601	27%	6,000	5,000
Medical Education (13)	13,127	13,761	136%	10,143	9,363
Total Council & Committee Expenses	$345,521	$357,575	97%	$370,343	$464,178
Contingency	$22,738	$27,085	60%	$45,000	$25,000
General/Administrative					
Administrative					
Salaries	409,917	567,697	100%	565,000	650,000
Payroll Taxes	30,867	43,824	97%	45,000	51,000
Pension Plan	22,324	31,367	63%	50,000	50,000
Health Insurance	56,700	67,106	103%	65,000	73,000
Disability Insurance	2,991	3,082	86%	3,600	—
Life Insurance	—	—	—	—	6,500
Staff & Officers	77,449	—	—	—	—
Staff Travel	—	14,434	111%	13,000	15,175
Officer Travel	—	8,818	147%	6,000	10,600
Officer Stipends	—	41,000	85%	48,000	56,000
Staff/Officers Miscellaneous	—	9,304	155%	6,000	10,000
Exec. Committee/Board of Trustees	—	4,668	72%	6,500	10,000
In-State Travel	445	—	—	—	—
Office Supplies	43,309	46,285	116%	40,000	50,000
Office Equipment (Repair & Service)	2,282	11,755	157%	7,500	17,000
Postage	51,915	26,638	48%	55,000	40,000
Telephone	21,731	19,901	83%	24,000	20,000
General Insurance	21,453	21,720	72%	30,000	25,000
Utilities	20,497	22,388	102%	22,000	22,000
Bldg. Services	4,573	3,025	60%	5,000	10,000
Bldg. Maintenance & Repairs	13,027	23,662	158%	15,000	15,000
Yard Maintenance	5,493	6,076	76%	8,000	8,000
Accounting & Audit	8,869	9,990	83%	12,000	12,000
Legal Services	5,053	57,372	229%	25,000	50,000
Computer Support & Operations (16)	13,855	56,845	71%	90,000	78,500
Dues & Subscriptions	5,324	3,391	68%	5,000	7,200
Awards & Contributions	2,429	3,143	105%	3,000	5,000
AMA Dues Commissions Paid to Counties	23,180	21,867	87%	25,000	25,000
AMA Delegation (14)	121,250	93,614	99%	94,900	94,700

OSMA 2000 Proposed Budget *(continued)*

	12/31/98 Year-End	12/31/99 Year-End	% of 1999 Budget	1999 Budget	2000 Proposed Budget
Generol/Administrotive (continued)					
Administrotive (continued)					
Depreciation	88,805	90,844	114%	80,000	80,000
Trustee Fees (Reserves)	4,132	4,120	137%	3,000	—
Coalition for Quality Patient Care	50,000	50,000	—	—	—
OCVO	—	165,601	100%	165,000	—
Other Operating	14,368	5,432	181%	3,000	5,000
Uncollectible PRP Loans	25,900	—	—	—	—
Totol Generol/Administrotive Services	$1,148,138	$1,534,969	101%	$1,520,500	$1,496,675
Progrom Services ond Support Expenses					
Councl/Committees	345,521	357,575	95%	370,343	464,178
Journal	139,203	154,045	95%	162,550	139,600
Annual Meeting	63,975	74,534	98%	75,850	78,545
Directory	—	—	—	—	18,000
General & Administrative	1,148,137	1,534,969	101%	1,520,500	1,496,675
Contingency	22,738	27,085	60%	45,000	25,000
Totol Progrom Services & Support Expenses	$1,719,574	$2,148,208	99%	$2,174,243	$2,221,998
Totol Support & Revenue	$1,992,431	$2,027,519	93%	$2,176,080	$2,232,938
Excess of Revenue over Expenses	$272,857	(120,689)	—	$1,837	$10,940

OSMA Member Service For-Profit Corporation 2000 Proposed Annual Budget

	12/31/98 Year-End	12/31/99 Year-End	1999 Budget	2000 Budget
Revenue				
C.L. Frates	4,500	6,000	6,000	6,000
I.C. Systems	3,921	1,850	4,500	1,500
Tax Resources	2,367	2,235	2,500	2,000
Autaflex	500	1,000	1,000	—
UPAL	1,000	0	1,000	—
TravCan	1,554	1,195	1,500	1,500
Quest	340	389	300	—
MBNA	12,500	0	0	—
Other	474	484	500	—
Bank Interest less charges	504	248	450	250
Totol OSMA Member Service For-Profit Corp. Revenue	$27,660	$13,401	$17,750	$11,250
Expenses				
Federal & State Taxes	5,886	5,494	3,000	3,000
Tax Preparatian	365	420	500	500
Other	874	—	—	—
Totol OSMA Member Service For-Profit Corp. Expenses	7,125	$5,914	$3,500	$3,500
Totol Revenue over Expenses	$20,535	$7,487	$14,250	$7,750

OSMA Education and Research Foundation 2000 Proposed Annual Budget

	12/31/98 Year-End	12/31/99 Year-End	% of 1999 Budget	1999 Budget	2000 Proposed Budget
Foundotion Revenue					
Bank Interest (Less Charges)	8,599	9,967	—	3,000	6,000
Restricted Grants	—	$2,500	—	—	--
Special Grants	—	$500	—	—	--
Totol Revenue	—	$12,967	—	$3,000	$6,000
Foundation Expenses					
Baard Meetings	—	135	—	—	500
Tax Preparatan	440	440	—	500	500
Miscellaneaus	—	5,768*	—	500	—
Grants	—	500	—	—	—
Totol Foundation Expenses	440	7,043	—	500	1,000
Foundotion Revenue over Expenses	$8,159	$5,924	237%	$2,500	$5,000
Physicion Recovery Program Revenue					
PLICO	125,000	125,000	100%	125,000	125,000
Oklahama Osteopathic Assaciatian	14,000	13,000	108%	12,000	12,000
Oklahomo Dental Assaciatian	12,000	12,000	100%	12,000	12,000
Cantributians — Other	—	1,000	400%	250	6,000
Total Physicians Recovery Program Revenue	$151,000	151,000	101%	$149,250	$155,000
Physicion Recovery Program Expenses					
Directar Contract (includes Secretarial Suppart, Hot Line, etc.)	84,000	89,000	100%	89,000	92,000
Assaciate Director (OKC)	12,000	13,200	100%	13,200	13,600
Assaciate Director (Tulsa)	19,157	19,500	100%	19,500	20,100
Travel (Director)	1,654	2,308	77%	3,000	3,000
Travel (Assaciate Directors)	—	2,479	83%	3,000	3,000
Pragram Laans	3,000	15,000	150%	10,000	10,000
Membership Dues (FSPHP)	—	300	60%	500	500
Brachures, Pragrams & Speakers	4,811	920	31%	3,000	3,000
Total Physician Recovery Program Expenses	$124,622	$142,707	101%	$141,200	$145,200
Physician Recovery Progrom Revenue over Expenses	$26,378	$8,293	103%	$8,050	$9,800
Medicol Education Progrom Committee					
Medicol Education Pragram Cammittee Revenue (15)	—	—	—	—	$65,000
Medical Educotion Pragram Cammitee Expenses	—	—	—	—	64,495
Medical Educotion Progrom Committee Revenue Over Expenses	—	—	—	—	$505
Totols					
Faundatian	8,159	5,924	237%	2,500	5,000
Physician Recavery Pragram	26,378	8,293	103%	8,050	9,800
Medical Educatian Pragram Cammittee	—	—	—	—	505
Total OSMA/ERF Revenue Over Expenses	$34,537	$14,217	135%	$10,550	$15,305

*$4760 (Medical Student Subsidy)
$1008 (legal expenses)
$5768

Journal of the OSMA Proposed FY 2000 Budget

Income	
Dues Allocation (Based on 3,719 members @ $30 allocation and 100 retired members @ $15	$113,070
Advertising	40,000
Subscriptions (Based on 68 subscriptions @ $45/ea.)	3,000
Total Income	$156,070
Expenses	
Journal Printing (Based on 11 issues @ $7,500/eo. and 1 issue [July, which carries the minutes of the HOD proceedings] @ $15,000. This figure is also dependent upon using a saddle stitch binding and offering no free reprints to authors.)	96,500
Postage/Mail House (Based on payment history)	8,000
Production Expenses (Includes proofreading, graphics/cover, etc. This amount reflects an increase over 1999 and is based on discussions about changing cover styles and other updates.)	7,500
Contract Services (Includes feature writing, photography, proofreading, etc*)	6,000
Editors' Fees (Based on 1 Editor-in-Chief @ $500/mo. & 8 editors @ $200/yr.) Note: As of October '99, we have 7 editors, but an 8th is expected to be odded.	7,600
Operating Expenses Includes such items os copyright expenses, professional association dues for managing editor, etc., as well as certain postage, long distance chorges ond other costs incurred by the agency with whom we hove a monagement agreement.	5,000
Manogement Agreement Based on the ossumption that the *Journal* will be brought back in house by April 1, 2000	9,000
Tatal Expenses	$139,600

*Denotes change. Some of these expenses (e.g. proofreading) were in other categories for the previous year. However, it is believed that these services can be monitored more carefully by including them in a single category.

Note: The figures above are bosed on continuing the *Journal* as it is currently being done. Any changes to the design, number of pages, or other modifications will almost certainly increase production costs.

Council on Professional Communications Proposed FY 2000 Budget

OSMA Newsletter $15,000

Based on printing 5,770 copies (September issue count) of o 4-poge newsletter with no additionol inserts. The breakdown is as follows:

Printing	$ 320
Paper*	520
Mailing	406
	$ 1,246
	x 12
	$ 14,952

* Blank "shells" are preprinted in lorge numbers to reduce costs. We generolly print o six-month supply in one print run.

Note: This does not allow for any add-ons, flyers, brochures or other materials that are often submitted for inclusion in the newsletter, nor does it allow for producing any 8-page newsletter, as has been done in the past unless that issue is a two-month one (e.g., January-February, etc.)

Faad/Catering 1,200

Based on 4 meetings per yeor

Website Maintenance & Development 10,000

Based on estimated costs for routine maintenance os well os improved graphics and additional pages.

Miscellaneous Expenses (artwork, photagraphy, etc) 1,500

Total $27,700

Council on Public Relations Proposed FY 2000 Budget

1. Call-In Radio Program "Oklohomo Health News Network"	$40,000
2. OSMA Promotional Items	5,000
3. Media	4,500
4. Council Meetings	1,000
5. Entertainment (Primarily, media lunches)	500
6. Trovel (Medio contacts, meetings, etc.)	1,000
7. Photography	1,500
Total	$53,500

Explanatian as fallows:

1. See attached estimate from Buckalew & Associates in the amount of $39,900. Other vendors in Oklahoma City were contacted and asked to bid, but no bids were received.
2. OSMA has virtually no specialty advertising items, and it is believed that this would be a good investment. For example, we could have given pencils or other small items to the schoolchildren who came to hear the Extinguisher as a reminder of OSMA's sponsorship in those local communities. This is another important element in attempting to establish a stronger public identity for the OSMA.
3. Consists of $2,500 for clipping; $1,000 for broadcost clips; and $1,000 for sending news releases through PR newswire.
4. Based on 5x/yr. Includes food, conference calls, etc.
5. If OSMA wants an active media campaign, it will require personal visits to media representatives throughout the state. These meetings typically take place over lunch.
6. See above.
7. If we have to depend on a commerciol photographer for all our needs, the cost would be exorbitant. During 1999 we have saved a considerable amount of money by taking photographs of news conferences, etc., ourselves and have utilized these photographs in all our publications.

2000 OSMA Annual Meeting Income/Expense Summary

Income		
Exhibit Sales		$10,000
15 Exhibit Booth spaces available @ $1,000		
5 Free Spaces - (OCVO, PLICO, 1999 Winner, OMPAC, Medicare)		
Spansarships:		$22,000
Educational Grants	$5,000	
Dignitaries, Inaugural Receptions	2,500	
Luncheon, Inaugural Speakers	4,500	
Inaugural Dinner	3,500	
OSMA Luncheon Table	200	
Caucus Breakfast, Executive	1,500	
Registration	1,500	
Program	1,000	
Refreshment Breaks	1,000	
New Officers Luncheon	1,000	
Board Lucheon	1,000	
Ticket Sales		13,875
Luncheon 75 tickets @ $25	$1,875	
Inaugural 200 tickets @ $60	12,000	
Inaugural Comp tickets 100		
Dues Allacatian		33,000
Tatal Income		$78,875
Expenses		
Exhibit Expenses		4,000
Decorotors/Supplies ($2,316.10)		
Printing ($1,984.88)		
Phatagraphy		1,300
Printing		11,000
(Annuol Meeting Registration, Programs, Invitations, Copying HOD moterials)		
Supplies		6,845
(Envelopes, Ring Binders, paper, divider sheets, ribbons, badges, etc.)		

Expenses (continued)		
Entertainment/Speakers		4,500
Luncheon Speaker	$1,000	
Executive Commitee Dinner	1,500	
Honorariums - Opening Session	1,000	
Annual Meeting Planning Meetings		200
Signs & Security		1,000
Audia/Visual Equipment, Misc. Equipment, Vating Machine		6,000
Awards/Traphies/Favars		3,000
Coasters		
Awards, i.e. Pres. Citation, plaques, etc.		
Gifts, i.e., President's spouse, speaker		
Hatel Expenses		40,700
Oklahoma City Westin - inclues AV	22,000	
Petty Cash, tips, etc.	300	
Inaugural - Cowboy Hall of Fome	17,500	
Facility Rental	2,000	
Dinner 35.00 x 300	10,500	
Entertainment/Speaker	3,500	
Reception	1,500	
Flowers	900	
Tatal Expenses		78,545
Inaugural Expenses		17,500
Inaugural Revenue		21,000
* Inaugural Reception	2,000	
* Inaugural Dinner	3,500	
* Inaugural Speaker	3,500	
Ticket Sales	12,000	
* sponsorships		
Tatal Expenses		78,545
Tatal Revenue		78,875
Total Revenue aver Expenses		$330

Council on Public and Mental Health 2000 Budget		
1. Public and Mentol Health Initiotives		$5,000
National Alcohol Screening Day	1,000	
Schools for Healthy Lifestyles	1,500	
Women, Girls, Tobacco, & Lung Concer	1,500	
Stroke Aworeness at Capitol	1,000	
2. Sub-Committee Project Monies (Cotering & Projects)		6,500
Perinatal SubCommittee	1,000	
Substonce Abuse Task Force	1,000	
Family Violence SubCommittee	1,000	
Liason to Tobocco Free Oklahoma Coalition	1,000	
Geriotrics Task Force (Two EOLC) Seminors	500	
Maternal Mortality	500	
Disaster SubCommittee	500	
HIV SubCommittee	1,000	
3. Clearinghouse/Public Heolth Information		1,000
4. Committee Meetings & Miscelloneous Expenses		3,000
Grond Total		$15,500

Oklahoma Medical Political Action Committee 2000 Budget	
Telephone Charges - Conference Calls for Meetings	$2,000
Office Supplies, Copying, Postoge	1,000
Cotering for Council Meetings	1,000
Bulk Moilings	3,200
Printing	3,600
OSMA Annual Meeting	1,000
Totol Budget	$11,800

Council on Governmental Activities 2000 Budget		
Contract Lobbyist (John Montgomery)		$25,000
Controct Lobbyist Miscellaneous Expenses		2,000
Total		27,000
Trips to Washingtan D.C: Date TBA (2 trips)		
Airfare - $500 per person for 4 people		4,000
Hotel expenses - $175 pp/3 nights/4 people		4,200
Meals - $75 per day/3 days/4 people		1,800
Totol Trips		10,000
Catering/Miscellaneous (yearly dinner with health aides)		3,000
Total Budget		**$40,000**

Council on State Legislation and Regulation 2000 Budget		
Contract Lobbyist		
LSW Consulting, Inc. (Lynne White)		$69,600
Dan Droper		36,000
Other Contracted Employees (Session Only) ond misc.		7,400
		113,000
Reimbursement of Lobbying expenses		2,000
Print newsletters, mailings, and Legislative Summary		9,000
Medicine Day and/or Doctor of the Day contact program		6,000
Doctor of the Day supplies		1,500
Legislative Conference Trovel		
Jonuary 12-15, 2000 Stote Health Legislation Meeting Miami Beach, Florida (Kathy)		
Air - $400		400
Hotel - $200/4 days		800
Meals - $75/4 days		300
		1,500
August 2000 AMA Advocacy Roundtable (Kathy and Lynne) Location to be announced		
Air - $400/2 people		800
Hotel - $200/2 people/4 days		1,600
Meals - $75/2 people/4 days		600
		3,000
Total		4,500
Legislative trocking service (GIT & LIN)		4,200
Copy & fox legislative bills and alerts		4,300
Legislator requested sponsorship		3,000
Catering for Council Meetings		2,500
Legislative dinners, contact lunches and dinners		2,500
Mail box at Capitol		500
Professional dues and publications		500
Miscellaneous		500
Total		$154,000

2000 OSMA Alliance Projected Budget Expense

OSMA Annual Meeting		
OSMA Annual Meeting Hotel Expenses		
Meals		
Past Pres. Breakfast		$300
Pres. Breakfast		220
Post Convention Lunch		650
Pre-Convention Thirst Quencher		170
Awards		65
Printing		
Programs (100)		300
Spiral Bound Report (50)		400
OSMA Alliance Directory		
Binders - na		
Graphics – na		
	Subtotal	2,105
Audio Visual, Misc.		395
	Total	$2,500
AMA Alliance Annual Meeting		
Hotel Expense 6/11-6/15 (1 staff)		825
Travel		300
Foods/Tips/Misc.		200
	Total	$1,325
Miscellaneous		
Medicine Day at the State Capitol - Refreshments		200
Mailings (Misc.)		100
Printing: OSMA Alliance Letterhead & Envelopes		500
	Total	$800
Sooner Heartbeat (Alliance Newsletter)		
Speed Press (Printing; 1400 copies)		January: 450
		March: 600
		August: 500
		November:500
Mailing (labeling, etc.)		4x@50 = 200
	Total	$2,250
AMA Alliance President Installation for Susan Paddock		
Reception		8,000
Awards, Decorations, Meals		2,000
	Total	$10,000
OSMA Annual Meeting		2,500
AMA Alliance Annual Meeting		1,325
Miscellaneous		800
Newsletter		2,250
	Subtotal	6,875
* **AMA Alliance Pres. Inaug.**		10,000
OSMA Support		5,000
	Total Budget Request	$21,875

*2000 only

OSMA - Medical Student Section 2000 Budget

AMA Annual Meeting Expenses - Chicago - 6 students		
Hotel (Approx. $200 per room - 2 rooms, 3 nights)		$1,200
Travel ($200 per student x 6)		1,200
Meals ($25 x 3 x 6)		450
Delegation Dinners		350
	Total	$3,200
Interim Meeting Expenses - Orlando, FL (4 people)		
Hotel (Approx. $200 per room - 2 rooms - 3 nights)		1,200
Travel (Approx. $300 x 4)		1,200
Meals ($25 x 3 x 4)		300
	Total	$2,700
Sectional Meeting - 6 people		
Location to be determined at December 1999 Interim Meeting)		
Hotel (Approx. $200 per room - 2 rooms - 3 nights)		1,200
Travel (Approx. $200 x 6)		1,200
Meals ($25 x 3 x 6)		450
	Total	$2,850
OSMA Board Meetings		
Travel Expenses		100
Programming		
Medicine Day at the Capitol		100
OKC Round Table Luncheons		800
Service Projects		150
First Year Recruitment Party		3,250
Special Events		350
	Total	4,650
	Total Budget	$13,500

Membership Budget

Special Projects	$4,500
Receptions for Residents, Non Members	
Survey of Residents, Medical Students	
Rural County Meetings	
Travel for Staff, Dinners, etc.	
Mailings	
Meeting Coterings	
4 x $60	240
Total	$4,740

Physicians' Campaign for a Healthier Oklahoma Proposed Revised Budget 2000

Budget Item		OSMA	OSDH	Total	Line Item Subtotal
Brochures -Layaut, design, praaf (ane-time)		550	550	1,100	
Phase I (50,000 @ $83/1,000)		2,075	2,075	4,150	
Phase II (50,000 @ $83/1,000)		2,075	2,075	4,150	
	Subtotol				$9,400
Posters - 1,000 @$1.23		615	615	1,230	
Film & color proofs (one-time)		279	306	585	
	Subtotol				$1,815
Literoture Holders - clear					
Phase I (500 @ $6.00)		1,500	1,500	3,000	
Phose II (500 @ $6.00)		1,500	1,500	3.000	
	Subtotol				$6,000
Adhesive logos (10,000 @ $.0224)		0	224	224	
					$224
Television Advertising					
TV pramatian/Take Care Campaign					
KWTV Channel 9		19,000	26,000	45,000	
KOTV - Channel 6		10,500	17,500	28,000	
Newspopers		100	100	200	
	Subtotol				$73,200
Other Promotionol					
Video tope praductian/local access		12,000	12,000	24,000	
(4 tapes @ $6,000)					
Videa capying		500	500	1,000	
PCHO Banner		0	75	75	
	Subtotol				$25,075
EMS Viols for Toke Core Compoign		10,000	10,000	20,000	
16,000 @ $1.25					$20,000
Promotionol Events					
Medicine Day laminated tags		107	100	207	
Miscellaneaus events		1,000	1,000	2,000	
	Subtotol				$2,207
Annuol Meeting					
2 Cardiavasculor Session Speakers		2,250	2,250	4,500	
PCHO Booth Fee		500	500	1,000	
Wolk the Canal far Health					
(100 @ $5.00)		250	250	500	
PCHO T-shirts (100 @ $6.00)		300	300	600	
PCHO Pencils (1,000 @ .18)		90	90	180	
PCHO Inaugural Pens					
(300 @ $5.00)		750	750	1,500	
(200 @ $2.00)		200	200	400	
	Subtotol				$8,680

Physicians' Campaign for a Healthier Oklahoma Proposed Revised Budget 2000 *(Continued)*

Budget Item		OSMA	OSDH	Total	Line Item Subtotal
PCHO Project - PPIP		1,000	1,000	2,000	2,000
Meeting Catering		1,000	0	1,000	1,000
Equipment					
Color Copier/Printer		600	0	600	
B&W Copier		8,000	0	8,000	
Loptop (2 @ 4,250)		8,500	0	8.500	
	Subtotal				$17,100
Supplies					
Tri-fold disploy		0	400	400	
Tobs for pockets		0	1,000	1,000	
Copier toner		0	300	300	
Tyveck envelopes - 1,500					
(100 @ $24)		0	360	360	
Copy poper, colors					
(100 reoms @ 5.50)		0	550	550	
White copy poper					
(110 reoms @ 3.00)		0	330	330	
	Subtatal				$2,940
Postage					
1,000 tubes @ $2.00		0	2,000	2,000	
$35/month x 11 months		0	385	385	
Poster Tubes (1,000 @ $.27)		135	135	270	
	Subtatal				$2,655
Telephane					
($180/mo. 11 mos.)		0	1,980	1,980	
	Subtatal				$1,980
Travel far PCHO presentations					
(5,500 miles @ .325)		1,788	0	1,788	
Lodging ond perdiem		736	0	736	
	Subtatal				2,524
Miscellaneaus		1,000	0	1,000	
	Subtatal				1,000
	Total	$88,900	$88,900	$177,800	$177,800

Council on Medicol Education 2000 Budget	
Revenue	
Hospitol Accreditatian	$7,000
Duncan Regianal Haspitol	
Hillcrest Medical Center	
Institute far Mental Health	
Orthapaedic & Recanstructive Reseorch	
Southwest Medical Center	
St. Anthony Haspital	
Valley View Haspital	
Cantributian fram dues	100
Annuol Fee 15 institutions x $250	3,750
Total Revenue	$10,850
Expenses	
Site Surveys	$4,000
Duncan (June)	
Hillcrest (December)	
Institute for Mentol Health (December)	
Sauthwest Medical Center (August)	
St. Anthany Haspital (May)	
Stillwater Medical Center (May)	
250 x 2 far eoch Hospital accreditatian	
Mileage for CME Coordinatar	
Trovel	$2,896
CME Chairman (Alliance CME)	
Conference Registratian	445
Flight	278
Hatel	500
Misc. (meals, tips, cab)	225
CME Coordinatar (Alliance CME)	
Conference Registratian	445
Flight	278
Hatel	500
Misc. (meals, tips, cab)	225
ACME Allionce Membership	195
Council Cotering	500
3-4 meetings per year	
Accreditation	
ACCME yearly occreditatian ($40 x 13)	600
PRA/Misc./Printing	572
100 baaklets	
System 98 on-site troining	600
Totol Expenses	$9,363
Totol Revenue Over Expenses	$1,487

OSMA AMA Delegation 2000 Budget AMA Delegation Expenses		
Annuol Meeting June 11-15 Chicaga (Hiltan)		
16 Delegotes @ 300 per doy for 7 days		$33,600
16 Delegates travel @ 300		4,800
Heort of Americo Coucus		
Breakfost Cost		2,250 (450 x 5)
Reference Sub Cammittee lunch		350
3 Staff travel @ 300		900
3 Staff hatel @ 200 (x 6 nights)		3,600
3 Stoff food/misc. @ 100 (x 6 days)		1,800
	Totol	$47,350
Interim Meeting December 3-6 Orlanda, Flarida		
16 Delegates @ 300 per day far 6 days		28,800
16 Delegates travel @ 400 (est.)		6,400
Heart of America Caucus		
Breakfast Cast		1,700 (450 x 4)
Reference Sub Cammittee Lunches		350
2 Staff travel @ 400 (est.)		800
2 Stoff hotel @ 200 (x 5 nights)		2,000
2 Staff food/misc. @ 100 (x 5 days)		1,000
	Totol	$41,050
Delegotion Meeting Costs		
OSMA Suite		5,500
Set up		
Soft drinks		
Food		
Supplies (cups, paper gaads etc.)		
Delegatian Caucus Lunch		300
Canference Colls, Moilings		500
	Totol	$6,300
Totol AMA Delegation Expenses		$94,700

OSMA Medical Education Program Committee Budget		
Expenses		$64,495
Cost of Accreditation		1,250
Pre-application	200	
Application	800	
Annual Fee	250	
OSMA Administrative Staff Support		15,000
OkACME Alliance sponsorship		1,500
CME Tracking Software		1,995
CME Programs		
Annual Meeting		2,900
AV	1,400	
Honororiums	1,000 *	
Mailings	500	
PLICO 52 hours		35,100
Honororiums	22,000	
Room charges	1,000	
Food	4,500	
AV	600	
Promotion	7,000	
Brochures		
Postage		
OSMA Programs		
EPEC (3) 30 hours		3,550
Room charges	250	
Food	1,800	
AV	500	
Mailings	1,000	
Brochures		
Postage		
All day CME (June) 10 hours		3,200
Room charges		500
Food		1,000
AV		500
Mailings		1,200
Brochures		
Postage		
Revenue		$65,000
PLICO		50,000
EPEC Income		7,500
25 attendees @ 100 x 3 programs		
All Day CME Income		7,500
150 attendees @ 50		

* *Majority of speakers presenting will be of no charge to the OSMA*

Year 2000 Computer Budget (revised 2/1/00)		
Monthly Fees & Maintenance Agreements		
Association Manager Software		
Extended Maintenance/Support		3,500
Progress Software Maintenance/Support		500
ISDN line & Internet Access for staff e-mail		5,000
Advanced Tech Hardware Maintenance		1500
	Total	$10,500
Equipment/Software		
Replacement/upgrade of older/outdated		
Work stations & software		10,000
	Total	$10,000
Services		
Advanced Image Systems or other contract		
(Network Administration/Programming)		36,000
Management Concepts:		
Special Projects		7,500
Report Writer Training (Accounting)		3,000
Reimbursement of Expenses		3,000
	Total	$49,500
Supplies		
Labels, Printer Ribbons, Toner, etc.		7,000
	Total	$7,000
Miscellaneous		
Office Staff - Computer Training		
Purchase of CD Rom/Video Training		1,500
		1,500
	Total	$78,500

REFERENCE COMMITTEE II

■ REPORT OF THE COUNCIL ON PLANNING AND DEVELOPMENT

CONSENT CALENDAR
Subject: Annual Report
Presented by: Mary Anne McCaffree, MD, Chair
Referred to: Reference Committee II
(A-2000)

Introduction
The Council on Planning and Development met twice during the 1999-2000 Association year: on May 23, 1999, and again on March 1, 2000, at the OSMA Headquarters in Oklahoma City.

The Council is comprised of the following OSMA members: President; Immediate Past President; President-elect; Vice President; Secretary-Treasurer; Speaker; Vice Speaker; Chair of the Board; Vice Chair of the Board; all Council Chairs; and AMA Delegates/Alternate Delegates.

At the May 23 meeting, Dr. Mary Anne McCaffree, OSMA Immediate Past President, welcomed Council participants and addressed the principle purpose of the meeting: to review and update the current OSMA goals and initiatives. To facilitate better group discussion and dialogue, Dr. McCaffree divided the participants into three working groups, each with staff. Each group designated one individual as Chair. The groups met for approximately one hour and then reported their results to the Council during a general session. Attachment 1 serves as a summary of this meeting.

At the March 1, 2000 meeting, Dr. McCaffree divided those present into two groups and asked each group to independently review the OSMA Mission Statement and Goals and Initiatives to determine if any changes are necessary. Both groups recommended and agreed on the amendments to the existing goals/initiatives (see Attachment I).

Recommendations
That the House of Delegates approve the revised OSMA Goals and Initiatives provided in this report.

Conclusion
Having looked very closely at the OSMA goals/initiatives during its past two meetings the Council will now begin to focus on other issues challenging the OSMA and the medical profession, including: OSMA Governance, Membership, Budget, future growth of the OSMA, partnership opportunities with County/Specialty Medical Societies, Fund Raising/Non-Dues Income.

Respectfully submitted.
Mary Anne McCaffree, MD, Chair

ATTACHMENT I

Oklahoma State Medical Association Goals and Initiatives
Draft

Goal 1: Assume a more active and visible role in promoting and improving health education.

1.1 Council on Public & Mental Health to target issues for OSMA active support.
1.2 Utilize press releases, internal publications, and other vehicles to provide health information to physicians and the general public.
1.3 Encourage MDs to promote public health and preventive medicine in their own offices and private practice with literature, pamphlets, and personal contact.
1.4 Work with the leadership of medical schools to ensure preventive medicine is included in curriculums and throughout medical training programs.
1.5 Partner with the Alliance in promoting public health initiatives.
1.6 Work toward expansion of the OCMS "Schools for Healthy Lifestyles" to the rest of the state.
1.7 Support the Board-appointed Task Force in the development of a comprehensive plan for a broad-based health initiative to improve the health of all Oklahomans.
1.8 Continue OSMA/Alliance involvement and leadership in public health community partnerships.
1.9 Develop an ongoing TV and radio program.
1.10 Continue to publicize the need for immunizations for adults and children.
1.11 Increase active and retired physician participation on state Boards and Councils through the legislative process.
1.12 Seek ways to publicly position physicians as the best source of medical information.

Goal 2: Increase physician membership and participation in OSMA.

2.1 Improve communication with the membership regarding OSMA and AMA activities.
- Assign a specific OSMA Officer and/or AMA Delegate/Alternate to each county medical society and ask them to participate in the society's meetings throughout the year.

2.2 Continue support of unified membership status.
2.3 Listen to OSMA non-members with regard to reasons for non-membership.
- Develop a non-member survey regarding items such as dues, etc.
- Activate the Committee on Membership Development.
- Develop a periodic letter outlining the benefits of membership and include in the *Journal*/Newsletter/Legislative Updates.
- Explore decreased dues for students, residents, and first-year practicing physicians.

2.4 Invite physicians individually to participate in Councils, Committees, etc. (especially physicians who are 35-50 years of age).
- Inform entire membership of the Council/Committees available - recruit yearly. Review all Council/Committees yearly to be sure all are representative of the membership.

2.5 Promote the benefits of participation in organized medicine.
- See 2.3 and 2.6.
- Make information available through electronic mail to encourage younger membership participation.

2.6 OSMA information should go to all members, not just 250, and develop a fax tree.
- Continue sending the Week in Review to OSMA leadership and develop a one-page OSMA update to all OSMA members and fax bi-monthly (written by Executive Director).

2.7 Increase the number of Board of Trustee Meetings to five - following the schedule below:
~~January~~ February
April
May - approximately one month following Annual Meeting
August
November

2.8 Promote DO participation - Officers, Councils, Committees.
2.9 Develop an Officer/Trustee/Council/Committee Chair Orientation Session.
2.10 Look into ways to increase interest in and attendance at OSMA Annual Meeting.

Goal 3: Increase participation in legislative and regulatory processes.

3.1 Increase grassroots involvement between physicians and legislators.
- Notify OSMA membership of their elected officials (State Representative and Senator) and provide telephone numbers of officials to OSMA members.
- Increase efforts to involve students/residents in the legislative process.

3.2 Promote the "Doctor of the Day" (DOD) to the membership.
- pager for "DOD."
- Develop a "key contact" physician program for each legislator.
- Attempt to secure pharmaceutical donations from drug manufacturers and/or pharmacists.
- Promote an annual "Medicine Day" at the Capitol.

3.3 Continue to enhance the Council on State Legislation and Regulation.
- Increase involvement of rural physicians.

3.4 Continue to develop an annual legislative agenda.
3.5 Continually upgrade technology to increase efficiency of legislation and political programs.
3.6 Add full-time and contract staff as necessary (and within budget) to support legislative monitoring efforts.
3.7 Increase the number of individual contributors to OMPAC and AMPAC.
- Increase the number of physicians willing to host legislative fundraisers.
- Increase the number of OMPAC contributors to 20% of the membership by the year 2010.

Goal 4: Assist OSMA member physicians in their dealings with managed care entities.

4.1 Remove any impediments to open discussion with patients regarding treatment options.
4.2 Actively promote legislation that would require Managed Care Plans to include and utilize organized medical staff structures for OSMA member physicians participating in managed care plans.
4.3 Support present physician-owned managed care organizations.
4.4 Establish a clearinghouse for managed care decisions and complaints.
4.5 Utilize the Ad Hoc Committee on HMO Medical Directors as a forum to promote quality of care standards for managed care.
4.6 Promote "due process" for physicians in dealing with managed care organizations.
4.7 Actively support a standardized credentialing process for managed care organizations.
4.8 Seek to require treatment and or evaluation decisions to be made by Oklahoma-licensed MDs/DOs in PPOs.
4.9 Support OSMA member physicians in their dealings with Medicare and HCFA.
4.10 Support OSMA member physicians with education and communications regarding federal regulations, coding, fraud & abuse, etc.

Goal 5: Increase the unity and collegiality of the medical profession.

5.1 Promote civility among physicians, even in disagreements.
5.2 Convince physicians that OSMA is the only organization in the state that crosses all lines to unify physicians.
- Increase efforts with urban physicians.
- Increase communication regarding importance of OSMA as single unifying entity (and member benefits).

5.3 Have OSMA act as a neutral source and find systematic ways of dealing with differences of opinion.
- Continue current process whereby large county medical societies deal with local grievances; others are referred to OSMA for mediation.

5.4 Explore avenues to reinstate physician courtesy for services rendered.
- Review existing laws and regulations.

5.5 Improve communication with OSMA members, specialty societies, etc. through:
- Public relations and better internal communication.
- Develop an orientation program for new Board members.
- Mentor new physician members.

5.6 Serve as a mediator for information from physician groups regarding complicated issues. Continue to obtain input of all members.
5.7 Utilize CME activities whenever possible to increase unity and collegiality in the medical profession.
5.8 Reach out to the membership through information technology.
5.9 Work toward future development of a hotline or e-mail chat room for medical office problems and for clinical medical problems or discussions.

Goal 6: Improve and enhance organizational effectiveness and membership services.

6.1 Continue to support and promote PLICO services.
6.2 Promote, enhance, and expand OCVO services/products.
6.3 Promote CME in all disciplines.
6.4 Continue to promote the availability of medical practice enhancement programs through educational seminars.
6.5 Develop a comprehensive membership recruitment program.
6.6 Improve communications; coordinate activities and available services between county and state societies.
6.7 Continually evaluate OSMA governance structure; i.e. protocols, constitution and bylaws, etc.
6.8 Conduct a periodic "needs survey" of the membership.

Goal 7: Communicate more effectively and efficiently with OSMA membership, patients, and the people of Oklahoma.

7.1 Utilize new technology (blast fax, e-mail, internet) to improve interactive communication.
- Enhance Internet website.
- Enhance physician use and awareness of computer technology.
- Incorporate MIS technology through addition of staff or contract services.

7.2 Public Relations.
- Evaluate most effective method of accomplishing goals related to public relations.
- Seek most efficient use of resources and return on investment.
- Evaluate current public relations efforts.
- Initiate press releases to communicate major activities to the media.

7.3 Integrate the Alliance as an equal partner in all OSMA activities.
7.4 Speakers' Bureau.
- Continue development of a physician speakers' bureau with input from the county medical and specialty societies.

REPORT OF THE COUNCIL ON MEDICAL SERVICES

FILED FOR INFORMATION
Subject: Annual Report
Presented by: James R. Claflin, MD, Chair
Referred to: Reference Committee II (A-2000)

Introduction
In its effort to "study, make decisions, and formulate activities with respect to the provision of medical care," the Council on Medical Services has primarily dealt with issues that assist our members in dealing with third party reimbursement and managed care. The Council has met quarterly since the last report.

Review of Activities
Oklahoma Health Care Authority (OHCA)
Steve Crawford, MD, updated the Council on the make-up of the Medical Advisory Committee (MAC), which he chairs. He recommended that the President of OSMA write a letter requesting that an OSMA member be appointed to the Committee. A letter was sent by Boyd O. Whitlock, MD, to the Health Care Authority recommending Marie Bernard, MD, and Robert Wright, MD, to serve on the Medical Advisory Committee. Marie Bernard, MD, now serves on the committee.

Oklahoma State Education and Employees Group Insurance Board (OSEEGIB)
The Center of Health Policy Studies (CHPS) submitted a study to OSEEGIB and made recommendations for changes to the provider fee schedules for physician, ancillary, and anesthesiologists services. The Council on Medical Services reviewed this study and recommended a letter to be sent to members of the Medical Services Council as well as the Rural Health Council asking them to contact OSEEGIB, their legislators, and the Insurance Commissioner regarding the problems they were experiencing, along with appropriate documentation. To date no council members have responded. It was also suggested that the physicians get their business managers involved.

SB 439, OSEEGIB
This is a new law effective July 1, 1999, that requires OSEEGIB to schedule a hearing thirty days prior to adopting any change of reimbursement rates and methodology. Contracted health care providers are to be notified at least fifteen days prior to the hearing. The notice to providers shall include proposed changes to rates and methodology. Relevant fee schedules shall be made available upon request to participating providers.

Fraud and Abuse Compliance Program
The Office of the Inspector General (OIG) is involved in auditing physicians' Medicare claims. OIG, as would be expected, has discovered a large number of inaccurate claims on the national level. If the OIG performs an audit and finds discrepancies, they can request their money back and levy a fine up to ($10,000) per claim.

ALL physicians' offices should have a Medicare compliance program. OSMA Legal Counsel, Linda Scoggins, developed an Audit Protocol modeled after the Idaho State Medical Association's compliance program. A letter outlining OSMA services available in this regard was mailed to all members on July 28, 1999.

Seminars
A seminar educating physicians on End-of-Life Care (EPEC) was held at the OSMA on June 18, 1999. Fifteen individuals attended. The seminar provided ten (10) Category I CME credit hours.

Electronic Pre-Certification
The Board of Trustees forwarded Resolution 2 (A-99) HOD action item: Electronic Pre-Certification to the Council on Medical Services. The resolution directs the development of standard electronic pre-certification eliminating some of the problems which prevent physicians from getting paid. The Workgroup for Electronic Data Interchange (WEDI) has been given the task from AMA leadership to establish an electronic commerce capability. Insurance companies have the capabilities to do this type of electronic paperwork activity. No action has been taken as of yet. Proprietary information will have to be made known to practitioners in order to utilize this type of system. The Insurance Commissioner will be queried to provide guidance.

The objective is to develop industry-wide standardized forms. A subcommittee met with members of the Medical Assistants Society to discuss their ideas on forms, hassle factors, and the main complaints on prompt payments. The president of the Medical Assistants, LaDee Hager, along with Allura Jones and Theresa Rieger, agreed to help the OSMA develop the means to deal with prompt and accurate payment problems. The short term goal is to collect various forms and find out what information is needed by insurance companies. The long term goal is to initiate a workshop for business managers, certified medical assistants, and others in the industry regarding forms. The Medical Group Managers Association and the osteopathic physicians will be contacted for additional information.

Prompt and Accurate Payment Project
As a result of the Hassle Factor Log, it was learned that most of the "hassles" that physicians experience from insurance carriers stem from a lack of prompt and accurate payment. This information has prompted the Council on Medical Services to start a prompt and accurate payment project. The AMA Advocacy Resource Center has developed a model campaign for prompt payment of claims, which has been sent to all state medical societies.

The Oklahoma State Statute regarding payment of claims was published in the OSMA's October newsletter so that members could become more familiar with the law and how to eventually collect from insurers. An end result of this project might be to enact better legislation to ensure prompt payment. An Ad Hoc Regional Committee was formed to collect data from certain areas of the state. Those volunteering were: John Perkins, MD; Jack Beller, MD; John Christiansen, MD; Boyd O. Whitlock, MD; Thomas Swafford, MD; and James R. Claflin, MD.

There are two prompt payment laws regarding the payment of insurance claims. One law under Title 63, subsection 2514, pertains to HMOs and OSEEGIB, while the other law in Title 36 Subsection 1219 applies to health insurance indemnity plans. In several other states, physicians have successfully taken insurance companies to small claims court.

Oklahoma Foundation for Medical Quality, Inc. (OFMQ) Update
OFMQ sponsored a fall conference on HCFA's (Health Care Financing Administration) Next Scope of Work. The Council was represented by Guy Fuller, MD, at the Oklahoma City location. He gave an update of a session that he attended at the 1999 OFMQ Fall Conference entitled ***The Sixth Scope of Work***, which dealt with certain health issues including: hypertension, influenza vaccines, heart disease, etc., and how HCFA can investigate these areas and request charts at random. OFMQ also has a new PEPP (Payment Error Prevention Program) that HCFA is implementing in February of

2000 to improve Medicare payments. The PEPP will audit hospitals and the efficiency of physicians to check on their coding for reimbursement.

All Products Clauses
The Council discussed the issue of **all products clauses**. Members were asked if they have been forced to join an insurance program in an "all or nothing" type package as a result of the Aetna/Prudential merger. No Council member has encountered any problems to date.

Prostate Cancer Drug
Information was distributed regarding a study for treatment for prostate cancer. The drug of choice is Lupron for a less costly treatment of prostate cancer. Lupron can be recommended in some cases in place of surgery. The company that makes Lupron is concerned that Medicaid/Medicare will not pay for its use, thus eliminating it as a less expensive alternative for some patients.

Y2K Compliance
HCFA administered a test run of their computer systems prior to January 1, making sure that they were Y2K compliant. Test kits were made available to any members to test their systems.

Subcommittees
Ad Hoc Committee on Managed Medicaid
This subcommittee, under the leadership of Mary Anne McCaffree, MD, has sent out a Medicaid survey to all active members of the OSMA. The responses will be compiled and used for statistical data. Around 200 responses have been received and two graduate students from the OU College of Public Health have volunteered to tabulate the data. The results should be ready by the end of April.

AMA-OSMA Physician Advocacy Medicaid Meeting Report
Mary Anne McCaffree, MD, gave a brief overview of the OSMA's concerns with the Health Care Authority. This included how SCHIP (State Child Health Insurance Program) money was spent over the past year, and the reduction in expenditures (physician and hospitals) in Medicaid to balance the budget. A teleconference took place on July 14, 1999, with the AMA regarding Medicaid and OSMA's legal counsel was present. Recommendations were made to improve the Oklahoma situation. These included: 1.) physicians need to submit their data; 2.) physicians need to develop a relationship with their legislators; and 3.) there is a need for physicians and patients to step forward as plaintiffs. If issues cannot be resolved through other means, the OSMA could possibly enter into litigation against the Health Care Authority, which could be a prolonged battle.

Four states have successfully sued Medicaid, and the AMA assisted these states with their fight. Possible legislation is another solution to this problem. Questions were raised as to which legislator would sponsor such legislation. It was reported that Sen. Angela Monson has expressed interest in such a proposal.

Mike Fogarty is the new CEO of the Oklahoma Health Care Authority and he will be working with key staff from the OSMA to try to establish a relationship between the two agencies.

Ad Hoc Committee on HMO Medical Directors
A letter was mailed to all of the HMO Medical Directors informing them of the need for OSMA physician leadership and the medical directors to communicate more effectively. As a result of the letter, a meeting was scheduled for November 3, 1999, in Stroud. Primary focus for discussion was the hassle factor logs.

James R. Claflin, MD, Chair, met with a few of the HMO medical directors in Stroud on November 3, 1999. He reported that there were 6 representatives present who worked for the HMOs. Those attending were: Cliff Peden, AMCare Health Plans; Dr. Paula Root, BlueLines HMO; Jimmy Durant, Executive Director of OK Association of Health Plans; Steve Sanders, DO, Pacificare; M. Joe Crosthwait, MD, PROklahoma; and Sally Venator, Heartland Health Plan. Susan Harmon, MD, from the Council was also present along with her office manager. Boyd O. Whitlock, MD, OSMA President, and Brian O. Foy, Executive Director, were also in attendance. The Hassle Factor Log was reviewed and the group agreed that there are five areas that they (HMOs) can work on to assist physicians with their problems.

Those areas include:
- Providing physician's offices with the proper address where claims are to be submitted;
- Standardized forms;
- In-office education of claims filing;
- Electronic pre-certification; and
- Clarification on ID cards.

The Committee met again on February 3, 2000, in Stroud with the following members attending: James Claflin, MD, Chair; Sally Venator, Heartland Health Plan; Boyd O. Whitlock, MD, OSMA President; W.F. Phelps, MD, Member of OSMA; Mark Dawson, MD, Aetna U.S. Healthcare, Inc.; Cliff Peden, AmCare Health Plans; Jimmy Durant; OK Association of Health Plans; M. Joe Crosthwait, MD, PROklahoma; and Jack Sommers, MD, CommunityCare HMO.

Items discussed included:
Standardized insurance forms
Discussions have been held with the Medical Assistants Association, which includes office managers. Their president, LaDee Hager, presented a form to her Board on February 12, 2000 for approval. It was approved. The form will be reviewed by the Council. The Ad Hoc Committee will discuss it at the next meeting on May 24th in Stroud.

Electronic Pre-certification
Discussion about electronic pre-certification indicated that some parameters will need to be set. The list of requirements needs to be small. The main challenge will be helping Oklahoma physicians understand the benefits of filing electronically. Several companies already do electronic filing on the internet, including Envoy and VOX. Jack Sommers, MD, Community Care, has visited some of these company's websites. VSI2000 and Vasona.com both have pre-cert and interquall criteria and offer feedback on referrals. Healthweb, acquired by Connectra, offers a unique service of identifying the status of claims submitted; eligibility issues; and also the option of checking the status of pre-authorizations.

Drug Formularies
Most HMOs and insurance companies are shifting towards a three-tiered drug formulary plan. The public needs to be educated about this, as well as employers who in turn can educate their employees. The Medicaid population could be educated through health screenings and health fairs conducted at certain schools as most of the Medicaid patients are children or families with children.

It was suggested that the OSMA do a series of articles in the OSMA *Journal* to educate physicians. Apparently, many years ago the OSMA had one-page, easy-to-read pamphlets on varied subjects. It was suggested that this would be something to try again as it was a success in the past.

The next meeting of the Ad Hoc Committee on HMO Medical Directors will be May 24, 2000, at 4:30 p.m., at the Stroud Conference Center.

Mayo Gilson, MD, Medical Director of Medicare Services

Mayo Gilson, MD, addressed the Council and informed them that his agency represents Part B of Medicare, or "the physician side." They have a contract with HCFA to carry out the duties of Medicare. Their initiatives are to create a fraud-free environment for Medicare.

Dr. Gilson recommended the OSMA's compliance program on Medicare Fraud and Abuse, written by Linda Scoggins, Esq., as a good resource.

Dr. Gilson reported that a big part of his job is just doing public relations work. His main job is to educate people who are Medicare beneficiaries. He recommended a website from Florida regarding Medicare Fraud, www.medicaretraining.com.

SUMMIT Program

Cindy Brown and Jennifer Free from the OK Insurance Department addressed the Council regarding the Insurance Department's SUMMIT Program. The Insurance Department received a grant from HCFA to educate senior citizens and train retired professionals to read Medicare statements. Their goal is to train seniors to recognize inaccurate information on their Medicare bills and to work with their health care providers to resolve those inaccuracies. Their next step is to do a series of training videos with the assistance of the OSMA. They will have their first program training in April and they hope to expand the program next year. Mayo Gilson, MD, offered the assistance of his office to the Insurance Department and the SUMMIT program.

Silent PPO (Preferred Provider Orgauizatious)

Explanation: Silent PPOs are brokers that buy negotiated rates from PPOs, and then sell those rates to payers who are not participants in the PPO and have no obligation to direct or notify patients. Both traditional indemnity insurers and health benefit plans with out-of-network options may purchase the right to access the silent PPO discount, but do nothing to direct care to the providers in the PPO network. Beneficiaries are unaware of any PPO arrangement and access services from providers of their choice. The payer applies the PPO discount to the beneficiary's claim when the provider submits the bill.

This practice results in providers losing revenue to which they are otherwise entitled. In addition, patients who may think that their health care bills are covered may be balance billed by providers who discover that a bill has been repriced through a "silent PPO"

It was noted that the state of Texas made the silent PPO illegal last legislative session. It was suggested a *Journal* article be written informing the OSMA members of this questionable practice.

The Council on Medical Services submitted a resolution to the House of Delegates to initiate legislation to halt the practices of the "Silent PPO." Also, the Texas Medical Society will be contacted to obtain background information on the subject.

DEA Resolution

Council members all indicated that they have been requested to provide their DEA numbers to various sources. Pharmaceutical companies track the drugs that are prescribed by using the DEA number. Dr. Claflin said that he would try to get a legal review from Linda Scoggins regarding this matter. There was great concern that these numbers should not be released. The AMA is also looking into this issue.

Oklahoma Health Care Authority/Summit Meeting

Joy Leuthard, OSMA Director of Health Care Policy and Research, reported that the OHCA has a FY 2001 Budget request of $1.9 billion. Part of this would encompass an increase which includes their Rural Health Care initiative, but at this time funding of this is questionable. They are possibly considering using part of the Oklahoma tobacco settlement money to fund this new initiative which is supported by the Governor.

Conclusions

The next meeting of the Council will be April 6, 2000, at 6:00 p.m.

Budget Request: $5,000

Respectfully submitted,
James R. Claflin, MD, Chair

■ REPORT OF THE MEDICAL STUDENT SECTION

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Amy Matzell, State OSMA/MSS Chair
Referred to: Reference Committee II (A-2000)

Introduction

The OSMA Medical Student Section consists of 318 members from the OU College of Medicine at the Health Sciences Center and the OU College of Medicine in Tulsa. The OSMA Medical Student Section is the largest extracurricular group on the Oklahoma City campus. The purpose of the Section is to introduce students to organized medicine and the issues that affect the practice of medicine.

Review of Activities

The Section will again sponsor its annual welcoming picnic for the incoming medical students. In August of 1999 the event was held at the Bricktown Ballpark and was attended by over 300 first-year medical students, OU faculty, and guests. Sponsorships to help fund the picnic were received from DuPont Pharmaceuticals, Ratcliff's Bookstore, PLICO, and the American Medical Association. The AMA supplied free gym bags for each student attending, and the OSMA gave away cups with the OSMA's logo. Students and guests enjoyed watching the Redhawks play Las Vegas. The 2000 picnic is again scheduled for the Bricktown Ballpark.

A new dues sponsorship program was initiated this year. The OSMA Board of Trustees voted to allow the OSMA Foundation to underwrite $40 of the $68 dues for each student who joined for the full four years. As an extra incentive, each student who joined for four years received a Stedman's Concise Medical Dictionary, 3rd edition, which included a CD-rom. These were made available courtesy of the AMA. This program was so well received that 133 students out of the class of 160 joined the OSMA and the AMA.

The Governing Council of the Student Section has continued to sponsor monthly Grand Round luncheons for the students with speakers on topics ranging from legislative issues to public health concerns. OSMA President Boyd O. Whitlock, MD, and Executive Director Brian O. Foy attended one of the noon luncheons and spoke to the students about the various councils and committees of the OSMA. As a result, several students volunteered to serve.

The Governing Council also scheduled a Roundtable meeting at OSMA headquarters on April 18. The topic was euthanasia and end-of-life issues. This type of function allows students attending to be able to discuss the issue with the presenters in a more individualized, small group setting. This year will be the first time this function has been held at the OSMA headquarters with a dinner provided.

Five students attended the Medical Student Section meeting of the American

Medical Association held December 2-5, 1999 in Chicago. Six students represented the OSMA at the Section III Conference in New Orleans on November 5-7, 1999. A portion of these trips are funded from OSMA's Student Section budget, and partly from the fundraisers held by the Section.

The Section will again be hosting the Annual Residency Fair on April 26 at the OU Health Sciences Center Library. Over 1,000 residency programs from across the nation have been invited to participate.

The 1999 OSMA membership application for students included a section listing four service projects and asked students to check those they were interested in. These projects included organ donation, Christmas in April, and an anti-smoking campaign. A group of students have already begun working with Dr. Mary Anne McCaffree on a children's anti-smoking campaign. Designed to target sixth graders, they will be going into schools making presentations to the children. This program will be ready to go by the fall. The students are attempting to secure a Policy Promotion grant from the AMA. These grants, in the amount of $250, are available to medical student groups interested in conducting projects and activities designed to further AMA policy or strengthen chapter activities.

The Student Section promoted and participated in OSMA's Medicine Day at the Capitol on March 22.

Each year the Section provides a 3rd Year Guide, which is aimed specifically to help the third year student, and has proven to be very valuable. The guide is put together by a member of the Governing Council, and advertising is sold to help raise funds for the Section.

Members of the Governing Council spoke with Dr. Boyd Whitlock and asked him to help revive interest in the OSMA among Tulsa County medical students. This would involve both OUCOM students in Tulsa as well as members of the OSU College of Osteopathic Medicine. It was suggested that physicians active in the OSMA and or Tulsa County Medical Society be asked to facilitate membership and help mentor a new chapter. A starting point for this project would be to elect a liaison from the Tulsa Campus to serve on the Governing Council.

The Student Medical Section and its Governing Council continues to be an active part of OSMA and appreciates the support provided by the Medical Association.

Budget Request: $13,500

Respectfully submitted,
Amy Matzell, MSIII, Chair

■ REPORT OF THE OKLAHOMA CENTRALIZED VERIFICATION ORGANIZATION, LLC

FILED FOR INFORMATION
Subject: Annual Report
Presented by: J. Christopher Carey, MD, Chair, Board of Managers
Referred to: Reference Committee II (A-2000)

Introduction

In January 1999, the Oklahoma State Medical Association (OSMA) assumed ownership of the Oklahoma Centralized Verification Organization, LLC (OCVO), positioning it as a statewide credentialing service. This twelve-year-old service exists to assist physicians and healthcare organizations by providing a quality centralized service for credentials data collection and verification.

After its transition to OSMA, the first Board of Managers was elected by the House of Delegates at the April 1999 annual OSMA meeting. Nine of the eleven members were divided into one, two, and three year terms of three members each. The remaining two positions are the Executive Director of OSMA and the current President of OSMA. This structure allows the board to always have a majority of experienced members, with three new members elected each year.

The calendar year of 1999 saw a growth rate of 31%, up from the average growth of 28%. Files received in 1998 were 5,378 compared to 7,028 in 1999. Nineteen new contracts were signed in 1999, which is the highest for any given year.

As we have discussed during this past year, commercial CVOs outside of Oklahoma have little penetration in this state; however, in-house healthcare system CVOs are becoming more prevalent. Two cases that particularly affected OCVO in 1999 include the acquisition of several hospitals by the Hillcrest Healthcare System, which centralized in-house, and the acquisition of Prudential Healthcare by Aetna, which has two in-house CVOs.

Even with the loss of these valuable organizations to the centralized reappointment program, OCVO has maintained approximately 46 clients in the program. There are very few centralized programs in the country, and ours is believed to be the second largest. Our greatest need now is to have additional clients that will overlap the areas already being serviced, as our low fees are based on duplication.

Pricing and timing are two critical and difficult areas to resolve. Figures were presented at the National Association of Medical Staff Services meeting last fall indicating that the average cost of verifying an initial application for a hospital is $786. While this figure will vary among organizations, the Board determined that OCVO's $250 full service fee should be increased to $300 in order to increase revenues to a workable level. Credentials verification organizations' (CVOs) fees around the country vary from $2 per element to $800 for a rush file. OCVO continues to have customized credentialing packages tailored to suit the needs of the client ranging from $10 to $500.

We must recognize that many of OCVO's functions are for the benefit of the physician while, with only a few exceptions, the healthcare organization is being charged for the service. Such services include: the maintenance of the data base to populate the application for the physician; centralizing the Pre-App process; centralizing the applications; coordinating among organizations so that one application packet is provided to a physician instead of multiples; centralizing the reappointment process to allow the physician to complete information one time in two years for multiple organizations; centralizing and re-using verifications so that the physician has fewer references to provide; maintaining credentialing office addresses so application packets can be provided directly to the appropriate personnel; and collecting expiring documents for distribution to multiple organizations. Because of our vision to be a comprehensive credentialing service and be responsive to physicians by providing these services, it is necessary to have additional personnel, equipment, and therefore expense.

Due to client expectations on reducing turnaround time, OCVO's need to become more electronic is increasing. Secure electronic access to the data base, image scanning, and user-friendly systems are necessary to reach these expectations. OCVO employees must know the intricate details of various accrediting bodies, licensing requirements, legal implications, and insurance regulations. This expertise must be matched with the electronic means to allow proper access and retrieval of confidential information.

OSMA physicians are the most valuable key to OCVO's success. When physicians encourage their hospitals and managed care plans to meet with OCVO about services, it sets the stage for a positive

relationship to develop. OSMA members above all are encouraged to notify OCVO of specific hospitals or managed care plans they wish OCVO to contact. Outpatient surgery centers are frequently in need of credentialing assistance. Physicians are asked to keep OCVO abreast of new surgery centers, hospitals, managed care organizations, group medical practices, and other healthcare organizations being planned or soon opening.

The uniform application development with the Oklahoma State Department of Health and other healthcare organizations was a major non-revenue project in 1999. The project had a good base to begin with due to core credentialing data being identified by the accrediting and licensing bodies on a national level. OSMA members requested that the OCVO form be used as the basis for the uniform application, which closely followed core data.

However, the state's new Peer Review law contained definitions and requirements that necessitated careful scrutiny of the uniform application to allow the physician's credentialing information to be protected as much as possible. This created development of the uniform credentialing application that contained information known in Oklahoma as "credentialing data" that would be discoverable. But it does not contain all information needed for each type of healthcare organization, so other information required in the process of credentialing will be obtained by each organization according to their own method, and should be privileged and confidential. Through client meetings and the help of legal counsel, a centralized addendum was developed for OCVO. While the uniform application is not as uniform as first envisioned when that law was passed in 1998, it still covers the majority of common information needed. OCVO provided classes to clients and non-clients regarding the proper use and storage of the uniform application and peer review information in accordance with the peer review attorneys.

OCVO has made available a blank uniform credentialing application through its web site, www.ocvo.com, or one can be completed for the physician by contacting OCVO. OCVO expects to have its data base completely upgraded to fill in all fields prior to the Annual Meeting. This is the largest single expense OCVO has incurred this past year at approximately $10,000.

Other new services included an 800 fax number (800-817-0432) for sources to reply to questionnaires or applicants to submit forms, documents, or other necessary information. While this is not a revenue-generating service, it has been extensively used for a nominal cost. This was added in response to sources requesting return postage for replying. Providing return postage would add an additional $25,000 to OCVO's annual budget, whereas the 800 number has added approximately $500 while increasing participant's satisfaction.

Upgrades in the computer network allowed OCVO to move into the year 2000 with no Y2K problems. An additional copier was added that also had printing features, allowing productivity to double for the process of putting together centralized reappointment packets. A number of other computers were enhanced to increase speed and memory capacity.

OCVO's customized credentialing software was upgraded to include a credentialing office address. As more physicians have a credentialing office away from their primary office, this new feature is critical in maximizing efficiency.

Through OCVO, OSMA has a valuable data base to expand credentialing services for the benefit of its members, but moving it forward does not come without expense. Many other states and commercial CVOs are spending as much as ten million dollars to build their data bases. We already have our data base in place, and are constantly upgrading the data as part of routine services.

Completing multiple credentialing applications has been a large expense to physicians. The uniform credentialing application is expected to save physicians several million dollars per year. OCVO was able to represent the physicians of Oklahoma in this endeavor. Software vendors around the country are meeting this summer to define the electronic data interchange (EDI) standards for credentialing. With well-planned and implemented electronic upgrades and systems, Oklahoma physicians can be relieved of much of the burden of even the uniform application; have their files handled faster; and have privileges considered or renewed sooner. Healthcare organizations can reduce their cost with more instantaneous information.

OCVO's proactive credentialing services are a vital aspect of OSMA's program for a healthier Oklahoma. It is an investment in our future.

We thank you for the support and financial contribution made to OCVO. Your suggestions are most welcome and your continued support is greatly appreciated.

Respectfully submitted,
J. Christopher Carey, MD, Chair

REPORT OF THE ORGANIZED MEDICAL STAFF SECTION

FILED FOR INFORMATION
Subject: Annual Report
Presented by: William O. Coleman, MD, Chair
Referred to: Reference Committee II (A-2000)

Introduction

The OSMA Organized Medical Staff Section was originally called the Hospital Medical Staff Section (HMSS). In June of 1995, the OSMA-HMSS was changed to the Organized Medical Staff Section (OMSS). It now credentials representatives from hospital medical staffs, as well as the other organized medical staffs from managed care groups.

The purpose of the Organized Medical Staff Section is to provide a forum for addressing common issues between physicians and organized medical staffs throughout Oklahoma. The OSMA-OMSS maintains communication, develops policy recommendations, and establishes and maintains relations with federal and state government entities having statutory or regulatory jurisdiction affecting organized medical staffs. The Section communicates its activities directly to the Board of Trustees and House of Delegates, as well as to the AMA-OMSS.

Review of Activities

William Coleman, MD, Chair, AMA-OMSS, and several other physicians represented the OSMA-OMSS at the American Medical Association meeting in Chicago on June 17-21, 1999. The activities were lengthy and a brief overview follows.

The AMA-OMSS met at the AMA Annual Meeting in Chicago to debate issues, take policy actions, and attend educational programs. The OMSS considered 31 resolutions and 14 reports. Twenty-nine resolutions were adopted, four reports were referred, three were not adopted, four were reaffirmed in lieu of AMA policy.

New AMA policy was adopted regarding OMSS action. The following favorable action was taken on the following items: formation of a national labor orga-

nization; coercive contracting; federal tax reform; the Medicare Pre-paid Competitive Demonstration Project; increased pharmacy risk-bearing; allocation of AMPAC funds; PRO Sixth Scope of Work; the distinctions between "supervision" and "proctoring" in the medical staff model and the legal implications; and the importance of independent legal counsel for the medical staff and conflict of interest disclosures.

Resolutions

Of the thirty-one resolutions at the AMA meeting, here are a few that are of major importance to the medical industry:

Resolution B1 - Patient Choice in Medicare Reform (submitted by OSMA-OMSS)

OMSS Action: Adopted Substitute Resolution B1 in lieu of Resolution B1

RESOLVED, that the AMA-OMSS Delegate to the AMA HOD be instructed to support the concept of HOD Resolution 131.

HOD Resolution 131 asks that the AMA actively lobby Congress for legislation providing Medicare beneficiaries with the option to purchase their own private health insurance; and that the AMA advocate the creation of an independent Medicare "Benefits Board" appointed by both the Administration and Congress, which would specify the detailed benefits, subject to an up-or-down vote by Congress.

HOD Action: Reaffirmed AMA Policy H-165.890 and H-330.968 in lieu of Resolutions 131, 132, and 136.

Resolution B2 - Federal Tax Reform (submitted by OSMA-OMSS)

OMSS Action: Adopted Substitute Resolution B2 in lieu of Resolution B2.

RESOLVED, That our AMA-OMSS Delegate to the AMA HOD be instructed to support the concept of HOD Resolution 215.

HOD Resolution 215 asks that the AMA actively advocate AMA policy H-165.920, which supports the development of Federal Tax legislation which would encourage the independent purchase of health insurance by individuals and families.

HOD Action: Adopted Resolution 215.

Resolution B14 - National Data Bank for Adverse Information on Physicians and Other Health Care Practitioners (submitted by William O. Coleman, MD, Chair of OSMA-OMSS)

OMSS Action: Adopted Amended Substitute Resolution B14 in lieu of B14.

RESOLVED, That our AMA without further delay or study, proceed to lobby the United States Congress to abolish the National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners (Title IV, Public Law 99-660, 1986); and be it further

RESOLVED, That the above resolution be submitted to our AMA HOD for consideration at its 1999 Annual Meeting

RESOLVED, That our AMA-OMSS Delegate be instructed to amend the second resolved of HOD Resolution 804 to read as follows:

RESOLVED, That if the AMA's negotiations with HCFA and appropriate agencies fail to achieve the above, the AMA have a top priority seeking a sponsor for federal legislation to gain protection for physicians.

HOD Action: Reaffirmed AMA policy H-355.991 in lieu of Resolution 239, and adopted Substitute Resolutions 803 in lieu of Resolutions 803, 804, and 811.

RESOLVED, That our AMA take all necessary actions to oppose and rescind the Health Care Integrity and Protection Data Bank. If it is not possible to repeal the establishment of the data bank, the AMA should take steps to protect the legal due process rights of practitioners.

AMA Interim Meeting 1999

The recent meeting of the American Medical Association's Organized Medical Staff Section (AMA-OMSS) in San Diego, California, December 2-6, 1999, was attended by the following representatives from Oklahoma: William O. Coleman, MD, Chair of the OSMA-OMSS representing the Deaconess Clinical Associates; Clarence Robison, MD, Caucus Chair of OSMA-OMSS, representing Mercy Medical Center; William Bernhardt, MD, Alternate AMA Delegate from Oklahoma, representing Midwest City Regional Hospital; Jay Gregory, MD, Delegate to AMA from Oklahoma, representing Muskogee Regional Medical Center at the AMA-OMSS; and Brian Foy, OSMA Executive Director, representing the OSMA staff.

Conclusions

The OSMA-OMSS hopes to expand representation by notifying each chief of staff and/or medical director of Oklahoma's hospitals and inviting them to come to the OSMA-OMSS Annual Meeting on Thursday May 4, 2000. The OMSS will continue to meet before the AMA Interim Meetings.

Budget Request: $2,650

Respectfully submitted,
William O. Coleman, MD, Chair

REPORT OF THE OSMA ALLIANCE

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Cheryl Baker, President
Referred to: Reference Committee II
(A-2000)

"Excellence Within the Heart of Our Community...OSMA Alliance" was the theme that I chose for my year as Alliance President. I have always felt that the works done by our Alliance members in the areas of health promotion, legislation, and fundraising for the AMA Foundation are some of the best and most rewarding volunteer efforts with which I have been associated. My experiences this year have done nothing but confirm this.

Following the State Convention at the Tulsa Marriott, I presided over the OSMA state Alliance Post-Convention Board Meeting and began my official duties as OSMA state President. Then on June 22, 1999, the AMA Alliance House of Delegates convened for the 76th Annual Session at the Drake Hotel in Chicago. Susan Paddack from Ada, Oklahoma, was installed as the President-Elect for the AMA Alliance for 1999-2000. Barbara Jett of Oklahoma City was also honored by being appointed to serve as chair of the AMA Foundation Committee. These achievements were the highlights for the Oklahoma delegation and a wonderful start to my year as OSMA Alliance President.

Beginning in August, President-elect Mary Ann Couch and I have had the opportunity to travel to many county Alliances and make and renew friendships in all parts of our state. We were welcomed by county alliances in Shawnee, Oklahoma, Muskogee, Ardmore, Norman, Ada, and Chickasha and had the opportunity to see and hear about the myriad of health promotion and legislative activities that are happening across the state. These could not take place without the dedication and hard work of all members, but a heartfelt thank-you is a must for all county presidents.

The Fall Board Meeting took place on September 13, 1999. Jeanne Morrison, our AMAA Field Director from Hattiesburg, was our special guest. Dr. Mary Anne McCaffree also gave a presentation on "Women & Girls, Tobacco &

Lung Cancer" which was adopted as our state health promotion project for the year.

We were also one of the last states to be visited by the Extinquisher, the AMA's anti-smoking superhero. During his week-long tour, this superhero and his side-kick Dr. Nola Know visited 14 elementary schools and presented their anti-tobacco performance to more than 1,400 children. I was thrilled with the overwhelming response of all Alliance members who participated and were involved in this rewarding health promotion effort and thank the OSMA who sponsored this event.

From October 2-5, five enthusiastic county Presidents and Presidents-elect joined Mary Ann Couch and me at Confluence I in Chicago. This AMA Alliance Training Conference was an excellent education and motivational opportunity, and all attendees came away with new ideas and information.

The OSMA Winter Board Meeting was held on January 10, 2000. Following the business meeting, Dr. Sara DePersio, co-chair of the Physicians' Campaign for a Healthier Oklahoma, presented a PowerPoint presentation to the Board on this newest health initiative from the OSMA. This is just the beginning for this preventative health program that will hopefully impact physicians, Alliance members, and patients in our state.

At that meeting, Kathy Musson was introduced as the new Executive Director of the OSMA Alliance, ably assisted by long-time Alliance friend Judy Lake. We are appreciative and thankful to Marilyn Fick who has assisted us for the past several years.

Medicine Day at the State Capitol was held on March 22, 2000. It was an important opportunity for the OSMA and the Alliance to make their impact on legislative issues that affect medicine. Sherry Strebel, OSMA Alliance Legislative Chair, was instrumental in the organization and success of this venture. We have appreciated her leadership in this area and thank her for her time and commitment to this effort.

The OSMA/OSMAA State Convention will take place from May 4-7, 2000, at The Westin Hotel in Oklahoma City. The OSMAA Convention co-chairs are Karen Mueller and Diane Brown, and they are planning a number of fun activities to coordinate with the Alliance meetings. The Pre-Convention Board meeting will take place on May 5, 2000, and our special guest will be Susan Paddack, AMAA President-Elect. Ann Hansen, AMA Alliance President, and Betty Haisten, Southern Medical Association Auxiliary, will be our featured guests at the OSMAA House of Delegates on May 6, 2000. Ann Hansen will preside over the installation of the 2000-01 OSMA Alliance officers.

I would never have successfully completed my year as President without the hard work and dedication of all members of the OSMA Alliance Board. In the area of membership, Linda Leemaster, First Vice-President, worked on maintaining and increasing our state membership numbers. She was also involved in a pilot program from the National Alliance titled "The Federated Membership Team." She was ably assisted by Barbara Jett, Vice-President of RPS-MSS, who recruited 67 new resident and medical student spouses. Holly Cathy did increase our number of members at large, and Karen Mask spearheaded the efforts to organize our newest county Alliance, the Great Plains Alliance!

Sandy Briepohl, AMA Foundation Chair, successfully coordinated the efforts to raise monies for medical education, research and service. Because of her hard work, over $30,000 will be presented to the medical school deans at the OSMA House of Delegates. Debbie Glasgow, Health Promotion Chair, coordinated efforts with county chairs to promote the state health promotion projects and received valuable feedback on health activities throughout the state.

Mary Ellen Tallerico made us all more aware of the origins of Doctor's Day and served as the coordinator of the Doctor's Day projects that will be judged at the state convention. Andrea Jones recruited members for OMPAC/AMPAC, and Linda Ruefer headed a successful Nominating Committee. President-Elect Mary Ann Couch acted as editor of the *Heartbeat*, our State Alliance newsletter. Joy Quinn chaired the Health Education Committee and with her committee reviewed applicants and selected two individuals who will receive the Ann Garrison Nursing Scholarships at the state meeting.

I would also like to thank Sandra Hook, Recording Secretary, Siham Ramadan, Treasurer, Judy Critchfield, Historian, Diane Cooke, Parliamentarian, Doris Edge, Bylaws, and Linda Leemaster, Finance Committee, for all their hard work. If we have successes during the year, it is due to the time and dedication of all members of the Board.

In addition to the Alliance Board, I would also like to thank Dr. Boyd Whitlock, OSMA President, for his inclusion of the Alliance on OSMA Committees. We have been busy on the Governmental Activities Council, Member Services Council, Public Relations and Communications Councils, Public and Mental Health Council, Education and Research Council, State Legislation and Regulation Council, as well as the task force for the Physicians' Campaign for a Healthier Oklahoma and Ad Hoc Committee for Firearms Safety. I have attended the Board of Trustees Meetings, and written several articles for the OSMA *Journal*.

Even as my year as OSMA President ends, the Alliance is already planning for the inauguration of Susan Paddack as American Medical Association Alliance President at the Drake Hotel in Chicago on June 12, 2000. Sherry Strebel and Barbara Jett are heading this committee, and it should be a wonderful event for all involved. What can be more representative of "Excellence Within the Heart of Our Community...OSMA Alliance!"

Finally, I would like to thank the OSMA staff for all their help and support as well as my husband Sterling, who has acted in the unofficial capacity as OSMAA proofreader. It has been my privilege to serve as the Oklahoma state Alliance President, and I have enjoyed this past year of opportunities in support of the Oklahoma State Medical Association Alliance.

Sincerely,
Cheryl Baker, President

REPORT OF THE PHYSICIANS' CAMPAIGN FOR A HEALTHIER OKLAHOMA TASK FORCE

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Robert J. Weedn, MD, Chair
Referred to: Reference Committee II
(A-2000)

Introduction

The concept of the "Physicians' Campaign for a Healthier Oklahoma" (PCHO) was developed during the meetings of the Oklahoma State Medical Association's Council on Long Range Planning and Development. It was approved by the House of Delegates at the 1999 Annual Meeting. The PCHO mission statement is "to improve the health of the people of Oklahoma by changing lifestyles and behavior with a focus on prevention." PCHO goals include: informing the public of the health status of Oklahomans, devel-

oping a plan to address those health problems and improve the health of Oklahomans, and emphasizing the responsibility of Oklahoma physicians to provide proactive leadership in health promotion. Strategies that have been developed focus activities in several areas including: prevention; education of patients, the public, and physicians; coalition building; and programs and services. During the past Association year, the Task Force met on May 12, 1999, June 16, 1999, July 7, 1999, August 18, 1999, September 29, 1999, October 27, 1999, December 8, 1999, January 12, 2000 and March 15, 2000. At those meetings the campaign goals, strategic priorities, campaign scope, and implementation objectives for the campaign were refined and developed.

Review of Activities

County Medical Society Presentations

These presentations have been well attended and received and include a summary of the *State of the State's Health Report* and a description of the OSMA's Physicians' Campaign for a Healthier Oklahoma. The Physicians' Campaign for a Healthier Oklahoma (PCHO) Task Force has given presentations in fifteen counties to county medical societies since September 1999. There are several more county medical society presentations pending and ultimately we hope to take the presentations to all county medical societies throughout the state. Local health departments have had representatives attend the presentations as well, contributing to the development of local physician and health department partnerships.

Other Presentations

Several other presentations have been given by Task Force spokesperson Gordon H. Deckert, MD. These presentations include: Kramer School of Nursing, St. Anthony sponsored program on stroke victims and caregivers, Oklahoma State Department of Health, and nursing homes and residential care facilities as well as many others. Other Task Force members have given presentations as well.

OSMA* Journal *Articles

Each month the OSMA *Journal* will include an article on prevention issues. Following each article will be a patient handout on a prevention topic to be copied and distributed by local physicians to their patients. The January *Journal* contains an article by Robert Weedn, MD, summarizing the Campaign's Task Force for a Healthier Oklahoma. The February OSMA *Journal* article is by Drs. David DeRose, James Crutcher, and Sara DePersio on *Improving the Health of Oklahomans Through Clinical Prevention*. The March OSMA *Journal* article is by Melissa A Mohon, MD, entitled *Do Physicians Counsel Smokers to Quit?*

Brochure and Poster

The PCHO Promotional Brochure and poster have been approved by the Task Force and are now available for use by physicians in their offices as a tool for assessing patients' lifestyles, suggesting ways to promote a healthier lifestyle and wellness. A letter has been sent to all active OSMA members introducing the brochure with an order form attached for physicians to obtain appropriate quantities of this material for use in their office. These same materials will be used in county health clinics throughout the state.

Extinguisher Program

The Extinguisher program has been transferred from the Council on Public and Mental Health to the PCHO.

On Thursday, September 23, the Extinguisher, a cartoon character created by the American Medical Association, and his creator and mentor "Dr. Nola Know" began a week-long tour of schools throughout the state championing the fight against tobacco use on behalf of American's children. Locations visited by the Extinguisher included Stroud, Chandler, Perkins, and Coyle on September 23. On September 24 he was seen in Oklahoma City, Kingfisher, and Watonga. On Saturday, September 25, the Extinguisher greeted the public at the Omniplex and Kirkpatrick Center Museum. Ada and Shawnee were the next locations for the presentation on September 27. Chickasha and Duncan on September 28 and Minco, Tuttle, and Norman on September 29 rounded out the Extinguisher visits in Oklahoma. The students as well as the school staff expressed great appreciation for the Extinguisher's visits through homemade cards and notes.

Given the budgetary constraints of the AMA, the Extinguisher program was suspended in the year 2000 because of its financial requirements, and has in fact been turned over to the American Medical Association Alliance and state medical society Alliances throughout the United States expanding the Extinguisher program throughout the nation. It is our hope that the Extinguisher program will be taken to every school in the state of Oklahoma by the OSMAA and its component county medical society Alliances in our war against tobacco.

Take Care Program

The "Take Care" campaign was successfully conducted in the Tulsa area in November 1999 with the sponsorship of Tulsa's KOTV-Channel 6 and three other local sponsors. As part of the program, Channel 6 aired a special OSMA/PCHO 30-second promotional announcement 69 times within the month of November. They also aired a five-part series of health news features on issues of concern to senior citizens during the noon edition and 5 o'clock edition of "The News on 6" and promoted the program in a number of other ways. The program generated thousands of requests for vials to be distributed to residents throughout northeastern Oklahoma. The campaign was very well received.

The "Take Care" campaign was launched in Oklahoma City on January 17, 2000 with the local sponsorship of KWTV-Channel 9. KWTV aired a special OSMA/PCHO 30-second promotional announcement throughout January. In addition, KWTV News 9 produced a news series on the importance of being prepared in the event of an emergency. The campaign produced a large number of requests for the vials.

The program is intended to help save lives by providing important medical information in the form of an EMS file where emergency personnel can easily locate it at the time of the emergency. The EMS file is a large amber vial containing a health questionnaire that lists vital medical information. The vial also contains a brochure entitled "Your Life, Your Health - Your Choice" explaining the Physicians' Campaign and providing information about risk assessment.

Negotiations are currently in progress regarding the EMS file containers with its producer and major sponsors that could take this program throughout the entire state of Oklahoma and contribute 500,000 vials.

Media Briefing

The Oklahoma State Board of Health, Oklahoma State Department of Health and the OSMA held a joint media briefing introducing the 2000 *State of the State's Health Report*. The briefing was held on Wednesday, February 3, 2000 at 10:00 am in the Blue Room at the state capitol.

Medicine Day 2000

Medicine Day 2000 was held at the state capitol on Wednesday, March 22. The

PCHO participated with a booth containing information on the tobacco issue, the Take Care Campaign, and other information concerning preventive medicine. Other booths included the Tobacco Free Oklahoma Coalition, Oklahoma State Department of Health Office of Tobacco Use and Prevention, and EMSA administering blood pressure checks.

Tobacco Settlement Issues

The Tobacco Settlement revenues were a major focus of the Task Force meetings. The need was emphasized to capture the attention of the public on this issue. Representative Jari Askins, Speaker of the House Benson, and others have filed bills in our Legislature to put tobacco settlement money in trust funds to protect it and keep it out of the general revenue so that it can be utilized for tobacco prevention, cessation, and education for children and other health care-related purposes in this state as well.

The Task Force endorsed the policy outlined in the Legislative Alert concerning the tobacco settlement revenues.

OSMA attended the press conference for the Legacy Foundation who visited Oklahoma in March. OSMA also attended a meeting with the Legacy Foundation CEO, Charles Wolf, and Cabinet Secretary Jerry Regier, seeking continued support of prevention programs.

Put Prevention Into Practice (PPIP) Readiness Survey

A survey of the OSMA membership was conducted to determine to what extent the physicians have incorporated or would be willing to incorporate prevention in their daily practice. The OSMA staff is in the process of tabulating the results of the survey responses. Students from the College of Public Health are assisting in the tabulation.

Meeting with Jerry Regier

PCHO leadership met with Jerry Regier, Cabinet Secretary of Health and Human Services, to discuss tobacco settlement funds and the Governor's rural health initiative. OSMA leadership conveyed their support of a trust fund for tobacco settlement funds.

OSDH Contract

The OSDH has pledged, contractually, support of the PCHO this year up to a maximum of $100,000 match of OSMA expenditures for this educational and prevention campaign.

1999 Resolutions

Resolutions passed at last year's meeting of the House of Delegates assigned to the PCHO have been addressed.

Youth Risk Behavior Survey #4 : 1) addressed during the county medical societies meetings; 2) letter sent to Sandy Garrett, State Superintendent of Schools; 3) Sandy Garrett replied with a letter of support for the OSMA and the OSDH efforts.

Clinical Preventive Services #9: New subcommittee formed - Prevention in Practice. First meeting March 23, 2000.

Oklahoma Two Year Old Immunization Level #10: 1) addressed during county medical society meetings; 2) OSMA served on Immunization Task Force with the OSDH.

Youth Suicide Task Force Late Resolution #22: Dr. Gordon Deckert appointed to Task Force in the fall of 1999.

Subcommittees

Prevention in Practice Committee

The PCHO Task Force formed an Ad Hoc Committee on PPIP (Put Prevention in Practice) to research if this program is the one OSMA wants to endorse as the program to promote clinical prevention among Oklahoma physicians. The program would provide a tool for physicians to use to begin giving surveys to their patients referable to preventive medicine and wellness and lifestyle.

The PCHO Ad Hoc Committee on PPIP has been renamed the Prevention in Practice Committee with Kent King, MD, as Chair. The Committee is in the process of forming a member roster. One goal of the Committee is to have a comparative report of official quotes and codes to show physicians the information regarding reimbursement for preventive services. Another objective is to develop a plan that can be piloted and be a resource for prevention through various means of communication. The Committee will stay current on the most effective methods of prevention and be a resource for the OSMA on preventive medicine in the physician's office. The first meeting of the Committee was postponed due to medical emergency and will be scheduled in April 2000.

Conclusion

As medicine evolves in the 21st century, there clearly will be a greater focus on prevention and self-care. Doctors need to be teachers as well as healers. Physicians' efforts will be better accepted if they work to enhance health and wellness as well as treat illness. Physicians should stimulate the public and patients to recognize and take responsibility for their own health through lifestyle modification. With compassion and concern for patients and the public, the "Campaign for Health" is a way to distinguish OSMA and its members as leaders locally and nationally. The campaign should show heart and help physicians win a place in the heart of patients and the public. Ultimately, the campaign is about behavior modification and lifestyle change. When one looks at the *State of the State's Health Report*, it is clear that lifestyle is a large part of what is killing Oklahomans and decreasing the quality of their lives. Physicians' Campaign for a Healthier Oklahoma sends a clear message that the Oklahoma State Medical Association and its members are working aggressively to solve the problem delineated by the *State of the State's Health Report.*

Budget Request: $88,900

Respectfully submitted,
Robert J. Weedn, MD, Chair

■ REPORT OF THE COUNCIL ON PROFESSIONAL COMMUNICATIONS

FILED FOR INFORMATION
Subject: Annual Report
Presented by: John C. Leatherman, MD, Chair
Referred to: Reference Committee II (A-2000)

Introduction

The Council on Professional Communications is given the responsibility for planning and conducting all activities of the Association with respect to interprofessional and *intraprofessional communications, all in cooperation with other Councils and Committees of the Association. The activities of the Council are governed by the Association's Annual Program of Activities as determined and interpreted by the Board of Trustees.* The *Journal* Editorial Board and the Web site/technology working group also fall under the purview of this Council.

Review of Activities

Video/Teleconferencing System

During the past year the leadership of the OSMA expressed an interest in exploring the options for an improved teleconferencing and/or videoconferencing system, and the Professional Communications

Council was asked to participate in this project. As part of this effort, a teleconference was held with the Director of Telecommunications for the AMA for the purpose of obtaining recommendations about how the OSMA might best communicate with rural physicians as well as with the AMA and Washington, DC. The possibility of developing a cooperative project between the AMA and the state associations for videoconferencing purposes was also discussed. As the subject of videoconferencing was researched in greater depth, it became clear that structural changes would be necessary in order to improve the acoustics of the Board Room. At that point, the project was referred to the newly established Building Committee for study.

Web Site

A variety of options were investigated during the past year for the purpose of improving the OSMA Web site. New features added by staff included putting the *OSMA News* and *Week In Review* online as well as providing a comprehensive Calendar of Events. The acquisition of a digital camera made it possible to include more photos on the site, and special events such as the media briefing for the *State of the State's Health Report* and the opening day of the legislature have been added to the site as they occurred. In late March an agreement was reached with The Worx Company, an Oklahoma City-based Web design organization, to revamp the site's appearance and to assist in switching from www.osmaonline.org to the new Web address, which is www.okmed.org. We have also registered the following additional domain names: www.okmednews.net and www.okhealthnews.net. Registering these names not only makes it possible for OSMA to move its Web site to an address that is easier to find and remember, but registering these additional names protects the organization from infringement by outside parties who might otherwise apply for those names and use them in a manner that could be confusing or embarrassing to the OSMA.

Publications

Following the Editorial Board's decision, endorsed by the Board of Trustees, to return the *Journal* back in-house, Erica Schwenneker has been hired as Publications Editor. Ms. Schwenneker was formerly employed by Public Strategies, the firm which had served as managing editor of the publication during the past year and a half. Ms. Schwenneker will also be responsible for producing the *OSMA News* and *Week In Review* and will assist in updating the Web site under the supervision of the Communications Director.

A special *Journal* report is attached as an addendum to this report.

Budget Request: $27,700

Respectfully submitted,
John C. Leatherman, MD, Chair

ADDENDUM

REPORT OF THE OSMA JOURNAL EDITORIAL BOARD

FILED FOR INFORMATION
Subject: Annual Report
Presented by: J. Michael Pontious, MD, Editor-in-Chief
Referred to: Reference Committee II (A-2000)

Introduction

The Editorial Board of the Oklahoma State Medical Association *Journal* is a subcommittee of the Council on Professional Communications; as such, this report is submitted as an addendum to the Council's report to the House of Delegates.

The *Journal* serves as the premier publication of the OSMA and includes both scientific and organizational content; it is a forum for the explanation and discussion of issues vital to the physicians and the practice of medicine in Oklahoma. The most recent survey of the OSMA membership indicated that 94% of members still get their information by reading. Sixty-eight percent of the survey respondents rated the *Journal* positively, and 55% felt its contents should be expanded.

The *Journal* Editorial Board met twice during the past year; contained in this report are accounts of their activities.

Review of Activities

During the October 7, 1999 meeting, the Editorial Board:

- Terminated the contract with Public Strategies, who had been serving as Managing Editor of the *Journal* since March 1998, reestablishing an in-house Publications Manager to oversee the *Journal* and other OSMA publications.
- Agreed to pursue a new graphic cover style for the *Journal*.
- Heard reports on the *Journal* advertising budget and advertising policies of the OSMA and other state medical associations.

During the March 15, 2000 meeting, the Editorial Board:

- Announced the following winners of the 1999 *Journal* awards:
 Best Cover Photo Award: Euan McMillan, MD, for his September 1999 cover featuring a white egret.
 Charlotte S. Leebron Award: Laurence Altshuler, MD, for his article entitled, "Alternative Medicine: What is the Physician's Role?"
 Mark R. Johnson Award: Sandeep N. Shah, for his article entitled, "Coronary Artery Disease in Women: A Silent Killer."
- Discussed the selection procedure for Leaders in Medicine honorees. Following discussion of the list of names, the Editorial Board elected to recognize Ray V. McIntyre, MD, and Floyd Miller, MD, as Leaders in Medicine.
- Selected, from several mock-ups, the new design of the *Journal* cover, to be introduced for the April issue. Photographs submitted by physicians and others will continue to be used for the front cover.
- Heard reports on the *Journal* operating budget and solicitation of new advertisers.
- Reviewed the terms of Editorial Board members. The three-year term of Ray V. McIntyre, MD, ended; he did not seek reappointment to the Editorial Board. David M. Selby, MD, was recommended to the Board for the three-year term as Editor vacated by Dr. McIntyre; the Board was asked to respond to the Editor-in-Chief with their suggestions for Editoral Board members before the Annual Meeting.

Recommendations

The Editorial Board recommends the following individuals be reappointed to one-year terms as Associate Editors of the OSMA *Journal*:

J. Michael McGee, MD
Ruth H. Oneson, MD
Johnny B. Roy, MD
Clifford G. Wlodaver, MD

The Editorial Board also recommends that David M. Selby, MD, be appointed to the open three-year term of Editor, joining M. Dewayne Andrews, MD (term expiring 2001), and J. Michael Pontious, MD, Editor-in-Chief (term expiring in 2002), as Editors of the OSMA *Journal*.

Additionally, all stipends for Editors shall be maintained at their current rate of $500 per month to the Editor-in-Chief and $200 per year to each Editor.

Budget request for the OSMA *Journal* is $139,600.

Respectfully submitted,
J. Michael Pontious, MD, Editor-in-Chief

REPORT OF THE COUNCIL ON PUBLIC RELATIONS

CONSENT CALENDAR
Subject: Annual Report
Presented by: Gary F. Strebel, MD, Chair
Referred to: Reference Committee II
(A-2000)

Introduction
The Council on Professional and Public Relations is charged with *planning and conducting all activities of the Association with respect to public relations and public service projects in cooperation with other Councils and Committees. The activities of the Council are governed by the Association's Annual Program of Activities as determined and interpreted by the Board of Trustees.* This has been interpreted to include media relations and other such external communications in support of the Association's goals.

Review of Activities
During its first year in existence, the Council undertook a number of activities on behalf of the Association, including the following:

"Take Care" Campaign
In November, in conjunction with the Council on Public and Mental Health and the Physicians' Campaign for a Healthier Oklahoma (PCHO), the Association served as one of the co-sponsors of the "Take Care" campaign conducted by Tulsa's KOTV, Channel 6. The program was very successful, and more than 18,000 vials were distributed to residents in the KOTV viewing area during the two-week project. In addition, a number of OSMA physicians were contacted for on-air interviews to discuss preventive health issues during the course of the campaign.

In January, a similar project was undertaken for the residents of Central and Western Oklahoma under the sponsorship of KWTV, Channel 9. During the first week of the campaign alone, the entire supply of 16,000 vials (4,000 for each of the 4 sponsors) was depleted. OSMA was then able to obtain an additional supply of 3,600 at a reduced cost by special arrangement with Senior Services, the organization which created the EMS File™. Senior Services has indicated an interest in partnering with the OSMA to distribute these vials throughout the state during the course of the year, with funding being underwritten by drug companies, medical supply companies and other sources. This project is under discussion, but there has been a clear indication of interest in partnering with the OSMA to expand the EMS File™ program from hospitals, fire departments, and senior citizen centers from around the state as well as from some state agencies. As one of the senior anchors on Channel 9 stated on the 5 p.m. newscast on January 20th, "This is one of the best programs our station has ever been associated with."

The PR Council expresses its thanks to Drs. Robert Mahaffey, Chair of the Council on Public and Mental Health, and Robert J. Weedn, Chair of the Physicians' Campaign for a Healthier Oklahoma, for their willingness to commit some of the resources allotted to those councils for this outstanding project.

Rapid Response Team Training
As the visibility of the organization increases, its leadership is increasingly called upon to discuss sensitive issues such as collective bargaining, medical errors, sales of products in physicians' offices, managed care conflicts, use of the tobacco settlement funds, and many other issues. In order to better prepare Association members to respond to media inquiries, a media training seminar was conducted at OSMA headquarters on November 13. Approximately 14 participants took part in the program, which was conducted by the AMA's premier media trainer, Pat Clark. The consensus of the group was that the program was extremely worthwhile, and plans are being considered to conduct similar workshops internally.

***Release of the 2000* State of the State's Health Report**
The 4th Annual State of the *State's Health Report* was released at a media briefing in the Blue Room at the State Capitol on February 3. The media was well represented at the media briefing, and media interviews are continuing to be generated as a result of this event.

Physicians' Campaign for a Healthier Oklahoma (PCHO)
In addition to other activities previously mentioned, a brochure and posters were produced to support the efforts of the PCHO.

News Conference for Dr. Nancy Dickey
In conjunction with Dr. Dickey's June 30, 1999, visit to Oklahoma City on behalf of the Oklahoma Academy of Family Physicians, OSMA was offered the opportunity to host a news conference. Dr. Dickey addressed the issue of the tobacco settlement monies at this event, which was well attended by the Oklahoma City print and broadcast media.

Public Relations Support to County Societies
Public relations support in the form of assistance with news releases and media contact lists has been provided to county medical societies as the function has gained visibility and requests have been received.

Medicine Day
Medicine Day at the Capitol was held on March 22. News releases were sent to print and broadcast media statewide. In addition, Take Care vials were distributed during the event (resulting in additional requests for the vials), and videotapes of the Take Care campaign news stories were displayed in the PCHO exhibit.

The Oklahoma Health News Network is a call-in radio program set to be launched in April. The program consists of providing a series of pre-recorded stories and scripted health tips at no charge to radio stations throughout the state. The stories include physician interviews, and the "health tips" are written for the radio announcers to read live. Each month a cover letter is prepared on special Oklahoma Health News Network letterhead that describes the stories for the month, which are furnished on CD or cassette or are available for downloading from a free 800 phone line. Also included in the packet are scripts for the live reads. The company that has been selected to perform this work on behalf of the OSMA is the same company which does a similar program for the Texas Medical Association, a project which has been extremely successful in that state.

Recommendations
The Council recommends that the public relations activities of the Association be continued and supported, particularly with regard to the radio program (Oklahoma Health News Network), the Take Care campaigns, and the ongoing media relations activities.

Conclusion
Through member surveys and by the adoption of the goals set forth by the Long-Range Planning Council, the membership has expressed its desire to increase the public relations activities of the Association. Toward that end, a public relations plan was developed and approved by the council that supports those goals. Public relations is a cumulative process, and a great deal of progress has been made in this area during the past year. It is anticipated that these activities will continue in a planned and systematic fashion as resources allow.

Budget Request: $53,500

Respectfully submitted,
Gary F. Strebel, MD, Chair

REPORT OF THE COUNCIL ON PUBLIC AND MENTAL HEALTH

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Robert M. Mahaffey, MD, Chair
Referred to: Reference Committee II (A-2000)

Introduction
It is the goal of the Council on Public and Mental Health to represent the Association in all matters related to public and mental health including, but not limited to, maintaining effective liaison with public and private organizations engaged in activities of this type, and the sponsorship of programs for the betterment of public and mental health. During the past Association year, the Council met on April 28, 1999, July 21, 1999, September 8, 1999, October 20, 1999, December 1, 1999, and February 23, 2000.

Review of Activities
Stroke Prevention Project
In 1995, the Texas Medical Association (TMASPP) introduced a stroke prevention program. This program, titled "Stroke Prevention Program of the '90s," was initiated in well over 80 Texas counties. The OSMA collaborated with the Oklahoma Stroke Coalition to benchmark the physician arm of this proposed comprehensive statewide program that has been in operation in Texas. DuPont Pharma is the educational funding source for this program.

On November 3, 1998, Tim Holder, MD, Chair, OSMA Stroke Prevention Program; Walter Buell, MD, Chair, TMASPP Stroke Prevention Program; Mike Wolfe, American Heart Association (Texas); and Alice Aldridge, TMASPP staff coordinator, met to discuss the details of initiating this program in Oklahoma. The target audience of this program is primary care physicians. The OSMA Stroke Prevention Program Committee includes Tim Holder, MD, OSMA; Brian Foy, OSMA Executive Director; Joy Leuthard, Director, Health Care Policy and Research. OSMA works in collaboration with the Stroke Coalition to include, but not limited to, the Oklahoma Academy of Family Physicians, Oklahoma Health Sciences Center, Oklahoma Stroke Coalition, and the Oklahoma Foundation for Medical Quality.

The Stroke Prevention Project offerings in Enid and Norman were held as scheduled; however, those in Edmond, Tulsa, and Lawton were cancelled due to low registration and faculty withdrawal. The Stroke Prevention Committee met on September 8 to regroup and discuss strategies. The Committee reviewed three major issues:

1) How to increase attendance;
2) Problems with faculty and syllabus; and
3) Ways to promote the project.

The Second Annual Stroke Screening at the Capitol, on Stroke Awareness Day, has been scheduled for May 23, 2000.

The Committee met a second time on Friday, March 17, 2000, and discussed revising the curriculum and possible rescheduling of the Tulsa location.

Ad Hoc Committee on the Oklahoma Health Ministries Association (OHMA)
The Ad Hoc Committee appointed by the Council to investigate OSMA's possible participation with the Oklahoma Health Ministries Association (OHMA), an organization that works promoting public health goals through local congregations, met on October 14, 1999. After much discussion, the Ad Hoc Committee decided to research in-depth the level of recognition the OHMA has in Oklahoma. Although the Committee applauds the goals and efforts of this ministry, it was recommended after the Ad Hoc Committee had its second meeting on November 11, 1999, that the OSMA not endorse the Heartland Chapter of the Health Ministries Association due to possible conflicts of interest.

Oklahoma Water Quality Hearings
The Council has taken a more active role in water and air quality issues and has had a Council member attend Oklahoma Water Quality Hearings. The OSMA Environmental subcommittee was reactivated.

Oklahoma Arthritis Network
A Council representative attended the first meeting of the Oklahoma Arthritis Network. A letter was sent to Neil Hann, MPH, Director, Office of Public Health Innovation at the Oklahoma State Department of Health, informing him of OSMA's support of this project and OSMA's interest in working with him and the Arthritis Network.

Medicaid Prescription Cuts
The current proposed Medicaid Prescription Cuts and proposed cut of the Medically Needy Program by the Oklahoma Health Care Authority was discussed by the Council. At a recent Oklahoma Health Care Authority (OHCA) meeting, supplemental state funding was approved to support the prescription and medically needed program.

1999 HOD Resolutions
Youth Risk Behavior Survey #4: 1) addressed during the county medical societies meetings; 2) Letter sent to Sandy Garrett, State Superintendent of Schools; 3) Sandy Garrett replied with a letter of support for the OSMA and the OSDH efforts.

Tobacco Control #6: 1) letter sent to Governor Keating from Boyd O. Whitlock, MD; 2) Council working with D. Robert McCaffree, MD, and the Tobacco Free Coalition; 3) vigorous lobbying efforts underway in 2000 Legislative Session.

Environmental Tobacco Smoke #7: 1) letter to Oklahoma City Municipal Council members; 2) letter from Dr. Whitlock to Board of Trustees Members.

Rotavirus Vaccine #8: Tabled at Council meeting due to rotavirus vaccine being withdrawn by manufacturer.

Oklahoma Two Year Old Immunization Level #10: 1) addressed during county medical society meetings; 2) OSMA served on Immunization Task Force with the OSDH.

Substance Abuse Task Force #13: Resolution amended by Substance Abuse Task Force and approved at November 1999 Board of Trustees meeting.

Folic Acid for the Prevention of Neural Tube Defects Late Resolution #20: The OSDH is conducting activities regarding folic acid and Mother's Day Campaign May 2000.

Youth Suicide Task Force Late Resolution #22: Dr. Gordon Deckert appointed to Task Force in the Fall of 1999.

Women and Girls, Tobacco and Lung Cancer Project

The Women and Girls, Tobacco and Lung Cancer Project, funded by the Chest Foundation, has progressed quickly. The Tulsa Public Schools have been contacted by the Tulsa County Medical Society's Women in Medicine Committee. Three thousand girls participated in skits and poster contests with the winner placed on a billboard.

Tobacco Use and Prevention Issues

The tobacco issue is the number one focus for the Council on Public and Mental Health.

- Dr. Whitlock wrote a letter to Governor Keating in July 1999 responding to a news release from Governor Keating on the Governor's statement on the distribution of the tobacco settlement monies.
- Talking points for physicians to contact their Legislators were developed. On June 17, the Board of Health passed a resolution supporting the Legislative Alert issued from OSMA. There was a consensus that physicians and legislators need to work together on this issue.
- The Tobacco Free Oklahoma Coalition (TFOC) and the OSDH Office of Tobacco Use and Prevention has prepared literature focused on improving the health and well-being of Oklahomans.
- A letter was sent to Dr. Vannatta concerning the disturbing lack of tobacco dependence curriculum being offered at Oklahoma medical schools.
- A letter of commendation was sent from the Council to the Oklahoma City Council members for their action regarding the Myriad and the beginning of a move to ban smoking from public buildings.
- A public hearing before the appropriations committee was held with OSMA members giving testimony. Robert McCaffree, MD, spoke on behalf of the Oklahoma State Medical Association and as Vice-Chairman of the Tobacco Free Oklahoma Coalition. He also spoke on behalf of patients who are suffering from the diseases caused by tobacco and the children we want to protect from the destructive effects of nicotine addiction and tobacco use.
- Dr. McCaffree and the Council reviewed information concerning the TFOC OnTrack Campaign. This information was introduced at a press conference at the State Capitol on March 2 with OSMA representation. The TFOC provided talking points for the Legislators. (Robert McCaffree, MD, will write an article for the OSMA March *Journal* about the TFOC OnTrack Tobacco Campaign.) On behalf of the OSMA, the Council on Public and Mental Health endorsed the TFOC's OnTrack Tobacco Campaign.
- An AMA resolution was reviewed by the Council concerning Tobacco Cessation Programs for Children. This resolution supports health plan coverage for adolescents/children of evidence-based approaches for FDA-approved pharmacotherapy, and other treatments of smoking.
- The Extinguisher completed his scheduled visits in Oklahoma. There was a great response from children and school staff. This project has been transferred to the Physicians' Campaign for a Healthier Oklahoma Task Force.

Small Working Group on Mental Health Providers

A small working group, chaired by Dr. Cleaver, was appointed by the Council to review the current rules and regulations governing mental health providers to decide what legislative action is needed and forward this recommended action on to the Legislative Council. This small working group met on October 12, 1999. The group recommended that Medicaid budget cuts be restored and encouraged the OSMA to participate in a coalition that deals with funding issues for health care, specifically related to the Oklahoma Health Care Authority.

College of Public Health Awards

Nominations were accepted by the College of Public Health and the University of Oklahoma Health Sciences Center for the Fourth Annual Public Health Excellence Award to honor those who have made outstanding contributions to public health in Oklahoma. The Council nominated Virgil Matthews, MD, Muskogee, and Gordon Deckert, MD, Oklahoma City, for this award. Dr. Matthews was chosen for the Professional Individual award.

SB 1469 - Creating Diabetes and Cardiovascular Disease Prevention, Education and Treatment Act

The Council strongly recommended support of the above bill and took this recommendation to the OSMA Council on Legislation and Regulation.

HIV Subcommittee

The Council discussed the need to keep the HIV subcomittee active. This was tabled until information could be gathered and further discussion occurs.

Subcommittees

Geriatrics Task Force

The first Educating Physicians on End of Life Care (EPEC) Seminar was held on June 18 and 19, 1999, at the OSMA Headquarters. The objectives of these seminars are to define and describe palliative care, provide an overview of state-of-the-art end-of-life care, to facilitate communication between patient, family, and care giver in end-of-life care and to enhance physician's management of pain and physician symptoms at the end of life. The Oklahoma City seminar was joint-sponsored by Deaconess Hospital for 10 credit hours of Category 1 CME. There were thirteen participants and seven speakers. The seminar was a success. The next seminar is scheduled for September 10 and 11 in Tulsa at the OUHSC.

Richard Boothe, MD, and Marie Bernard, MD, attended the EPEC Training Session in Chicago, July 16 - 18.

The Task Force met on August 16 and October 18, 1999, November 8, and March 8, 2000. The second of the Educating Physicians on End of Life Care (EPEC) Seminars was held in Tulsa on September 10 and 11. The Tulsa Seminar was joint-sponsored by Hillcrest HealthCare System for 10 credit hours of Category 1 CME. There were 24 participants with a waiting list. The seminar was very well received.

A partnership has been developed between the Texas Medical Association and the Task Force to present an End of Life Care (EPEC) Seminar in the Lawton area on April 28 and 29, 2000. The location has been set at the Comanche County Hospital. A brochure has been developed and is available. The Texas Medical Association will have faculty to co-pre-

sent some of the topics as Texas physicians are going to attend as participants.

Substance Abuse Task Force
The Task Force met on September 15, 1999. After much discussion, Resolution #13 was revised and presented to the Council at the October 20, 1999, meeting. The Task Force discussed the OSMA Annual Meeting CME Program for 2000 and developed several goals including speakers and topics for the Annual Meeting. The Task Force will participate in the National Alcohol Screening Day on April 6, 2000.

Disaster Preparedness Committee
The subcommittee held its first meeting on August 24, 1999. They stressed the need to develop a prepared list of volunteers to get preapproved through the Red Cross thus saving time in a trauma situation. One goal of the subcommittee is to gather and disperse information in a timely and up-to-date manner. Dr. Leatherman, Chair, met with Mr. Albert Ashwood of the State Emergency Management Team on August 27 with the focus on the integration of the OSMA as a full and active member of the team.

The subcommittee held its second meeting on November 3, 1999. The subcommittee members discussed the Metropolitan Medical Response System (MMRS) information and correspondence from Mike Murphy, MMRS Coordinator. The MMRS system is still under the process of being developed and will go before the Medical Control Board of EMSA for review. The subcommittee also reviewed information from Bob Roberts, Senior Associate, Planning & Preparedness, Emergency Services, Tulsa Chapter, describing the structure and purpose of the American Red Cross.

Maternal Mortality Committee
Drs. Rhoades and Nettles met with the OSMA and Oklahoma State Department of Health staff to begin to re-establish regular meetings of this Committee. In March, Dr. Nettles and Dr. Parekh will review cases from the past few years to "catch up" the process. Then formal Committee meetings will be resumed. A roster of Committee members has been established.

Family Violence Subcommittee
The subcommittee met on Monday, February 28, 2000, with Howard Shaw, MD, as the new Chair. Physician education and awareness of family violence was discussed as the purpose and direction of the subcommittee. The OSDH project *Intimate Partner Violence* was discussed at length with the subcommittee working with the OSDH is promoting this project. Various CME and education programs were addressed. The next meeting of the subcommittee is scheduled for May or June.

Conclusions
The Council on Public and Mental Health is dedicated to provide the citizens of Oklahoma, as well as OSMA members, with timely information regarding the medical aspects of public and mental health and to oversee programs in these areas. The next meeting of the Council on Public and Mental Health is scheduled for Wednesday, May 17, 2000 at the OSMA Headquarters.

Respectfully submitted,
Robert Mahaffey, MD, Chair

Annual Meeting Scrapbook (*continued*)...













REFERENCE COMMITTEE III

■ REPORT OF THE AMA DELEGATION

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Jay A. Gregory, MD, Chair
Referred to: Reference Committee III
(A-2000)

Introduction
The OSMA Delegation to the American Medical Association (AMA) represents the OSMA at both the Annual and Interim Meetings of the AMA House of Delegates.

The OSMA Delegation is currently comprised of 8 delegates and 6 alternate delegates; four delegates and four alternate delegates are elected at each OSMA Annual Meeting. Jack Beller, MD, is completing the term of Perry A. Lambird, MD, and Barbara Hastings, MD, resigned. The current Delegation is as follows:

Delegates
Jay Gregory, MD, Chair
David L. Harper, MD
Norman Dunitz, MD
Gary Strebel, MD
Mary Anne McCaffree, MD
W.F. Phelps, MD
Jack J. Beller, MD
William Hall, MD

Alternates
William G. Bernhardt, MD
Bruce Storms, MD
Susan Harmon, MD
Greg Ratliff, MD
Carl Hook, MD
Mukesh Parekh, MD

The Oklahoma Delegation also introduced a memorial resolution in honor of Perry Lambird, MD, a long-time delegate from Oklahoma City (see Attachment I). This resolution was acknowledged during the Opening Session of the AMA House of Delegates on December 5, 1999.

Review of Activities
1999 AMA Annual Meeting
Also in attendance from Oklahoma at this meeting were: Boyd O. Whitlock, MD, Tulsa, OSMA President; K. Mehta, MD, Chair, OSMA-IMG Section; D. Robert McCaffree, MD, Oklahoma City, Delegate, American College of Chest Physicians; and William O. Coleman, MD, Chair, OSMA-OMSS.

Members of the OSMA Alliance attending: Cheryl Baker, OSMAA, President; Diane Cooke, OSMAA Past President; Mary Ann Couch, OSMAA First Vice President; Linda Leemaster; Karen Mask; Barbara Jett, AMAA Nominating Committee; and Susan Paddack, AMAA Alliance Secretary. Medical Student Section members attending: Aaron Sapp, MSIV and Kris Wagner, MSIV.

The OSMA Delegation caucused each morning beginning Saturday, June 19 through Thursday, June 24 to review resolutions and House actions. The Delegation met on a daily basis (Sunday through Wednesday) with delegates from the states of Kansas, Missouri, and Arkansas, known collectively as the "Heart of America" (HOA) Caucus.

Alliance Activities
Susan Paddack of Ada, Oklahoma was installed as the President-Elect of the American Medical Association Alliance on Tuesday, June 22, 1999, at the Drake Hotel in Chicago. A large contingent of Oklahoma Delegates and Alternates were in attendance, as well as AMA Alliance members and OSMA staff.

AMA Commission on Unity
Mary Anne McCaffree, MD, was chosen to serve on the AMA Commission on Unity at the I-98 Meeting.

Meeting Highlights
Your OSMA Delegation and the members of the AMA House of Delegates deliberated over 85 reports on a multitude of issues generated by the AMA Board of Trustees, Councils, and Committees; as well as approximately 198 resolutions authored by state and specialty societies, AMA sections and commissions.

Significant actions taken by the AMA House include the following:

- approval of a report recommending (in part) that the AMA immediately implement a national negotiating organization, under the National Labor Relations Act, as an option for (a) employed physicians, and (b) residents and fellow physicians who are authorized under current state laws to collectively bargain; and that the AMA

- continue support for the development of independent house staff organizations for residents and fellow physicians, with the additional directive that the AMA be prepared to move ahead with a national labor organization in the event the National Labor Relations Board gives residents and fellows approval to collectively bargain under the National Labor Relations Act; and that the AMA

- continue its vigorous support for antitrust relief for physicians and medical groups and the creation of a national organization to support development and operation of local negotiating units. <u>These units would provide an option for self-employed physicians and medical groups consistent with the provisions of the Quality Health Care Coalition Act of 1999 (H.R. 1304) introduced by Tom Campbell (R-Calif.), or similar federal legislation, when enacted.</u> (A detailed report of this action was mailed to all OSMA members in a letter from the President dated July 8, 1999.)

- adoption of a report of the Council on Ethical and Judicial Affairs (CEJA), which addresses physicians who sell non-prescription, health-related products from their offices. The report recommends that health-related products should not be sold where benefit claims lack scientific validity. The report also recommends the following guidelines that are designed to limit conflicts of interest, minimize the risk of brand endorsement, and ensure a focus on benefits to patients: 1) to make useful health-related products readily available to patients, health-related products may be distributed free of charge or at cost; 2) physicians generally should not sell a health-related product when patients can obtain a product that offers the same medical benefit at a local pharmacy or health-products store; 3) physicians must fully disclose the nature of their financial arrangement with a supplier or manufacturer to sell health-related products; 4) upon request, physicians should provide patients with understandable literature that relies on scientific standards in addressing the validity of the health-related products. Physicians should not engage in exclusive distributorships of health-related products in which the products are only available through physicians' offices.

- referred to the Board of Trustees a CEJA report which addresses physi-

cians' responsibility to recognize impairments in driving ability that may pose a strong threat to public safety and which ultimately may need to be reported to the Department of Motor Vehicles (DMV).

- adopted a report of the Board of Trustees which summarizes the history and current status of negotiated rulemaking for lab tests that have been conducted by HCFA. The report recommends that the AMA reaffirm its policy to seek repeal of Section 4317 of the Balanced Budget Act of 1997 granting the Secretary of HHS authority to require submission of diagnosis codes with every lab test claim.

- adopted a report of the Board of Trustees which recommends that: 1) the American Medical Association continue to employ a variety of tactics to advocate HCFA adoption of AMA policy positions; 2) that the AMA continue to work cooperatively with HCFA, when possible, to achieve its policy objectives; 3) that when advocacy efforts directed at HCFA fall short of achieving AMA policy objectives, the AMA continue to seek congressional action, including oversight hearings and enactment of legislation; and 4) that the AMA use appropriate legal means, including suing HCFA, when appropriate and warranted.

- adopted as amended a Council on Medical Education report, which amends AMA policy to reflect that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory.

- adopted as amended a resolution directing the AMA to encourage pharmacies, insurance companies, pharmaceutical companies, and state Medicaid programs to use a number created and supplied by the AMA and linked to the AMA-ME number for physician identification purposes.

- adopted as amended a resolution directing the AMA Board of Trustees to appoint an Ad Hoc Task Force composed exclusively of full-time, actively practicing physicians charged with identifying problems in and proposing solutions for the E&M documentation system; and that the AMA work with HCFA to fully implement, test, and appropriately evaluate E&M pilot projects prior to adopting a new E&M documentation system. (The OSMA has nominated Jack Beller, MD, OSMA Secretary-Treasurer and AMA Alternate Delegate, to serve on this Task Force.)

- reaffirmed AMA policy in opposition to mandatory requirements that a patient's physician turn over inpatient care to a "hospitalist."

AMA Election Results
The following are the results of the AMA elections held on June 23, 1999:

Officers
President: Randolph D. Smoak Jr., MD
Speaker, House of Delegates:
Richard F. Corlin, MD
Vice-Speaker, House of Delegates
John A. Knote, MD

Trustees
Duane M. Cady, MD (NY)
*J. Edward Hill, MD (MS)
*D. Ted Lewers, MD (MD)
*Donald J. Palmisano, MD (LA)
Liana Puscas, MD (CA) (Resident Position)
Joseph A. Riggs, MD (NJ)
*incumbents

Jay A. Gregory, MD, Campaign
Several campaign dinners and lunches were held for Dr. Gregory, as well as a reception hosted by the Oklahoma State Medical Association on Monday, June 21, 1999. All expenditures relative to the campaign were within budget. Dr. Gregory was ultimately unsuccessful in his bid for a seat on the AMA Board of Trustees.

OSMA Resolutions
The following specific actions were taken by the AMA House of Delegates on seven resolutions introduced by the OSMA Delegation.

1. Resolution 131 - Patient Choice in Medicare Reform

RESOLVED, That the American Medical Association actively lobby the Congress of the United States for legislation providing Medicare beneficiaries with the option to purchase their own private health insurance; and be it further

RESOLVED, That the AMA advocate the creation of an independent Medicare "Benefits Board," appointed by both the Administration and Congress, which would specify the detailed benefits, subject to an up-or-down vote by Congress.

AMA Action: Reaffirmed AMA policies H-165.980 and H-330.968 in lieu of Resolution 131.

2. Resolution 213 – Fraud and Abuse

RESOLVED, The Oklahoma State Medical Association commends the AMA for its efforts to combat the new AARP-HHS initiative against alleged health care fraud and abuse, and be it further

RESOLVED, That the AMA use all possible legal remedies to defeat this misguided and poorly conceived attempt by the AARP and HHS to reduce alleged health care fraud and abuse.

AMA Action: Reaffirmed current AMA Policy.

3. Resolution 215 – Federal Tax Legislation

RESOLVED, That the AMA actively advocate AMA policy H-165.920, which supports the development of federal tax legislation which would encourage the independent purchase of health insurance by individuals and families.

AMA Action: Adopted.

4. Resolution 609 – Training for AMA Delegates/Alternates

RESOLVED, That the Speaker of the AMA House of Delegates review ~~immediately develop~~ the ~~a~~ formal training program for all delegates and alternate delegates to ensure that the program thoroughly familiarizes ~~them~~ delegates and alternate delegates with the proper role, responsibilities and requirements ~~expectations of what is required~~ to be an effective delegate; ~~and, be it further~~

RESOLVED, That the AMA Delegate/Alternate Training Program include special emphasis on a delegate's responsibilities before and after an AMA meeting, including responsibilities regarding membership and the communication of policy actions by the House of Delegates.

AMA Action: Adopted as Amended.

5. Resolution 714 (changed to 141) – Local Medical Review Policies

RESOLVED, That our AMA continue to seek repeal of medical necessity documentation requirements for laboratory work; and be it further

RESOLVED, That if outright repeal of medical necessity documentation requirements for laboratory work is not possible in any given session of Congress, then our AMA seek by legislative or judicial means the immediate termination of local medical review policies for laboratory work.

AMA Action: Reaffirmed existing AMA policy.

6. Resolution 820 - "Abuse of the Medical Record for Regulation or Financing the Practice of Medicine"

RESOLVED, That ~~the~~ our American Medical Association, ~~as the traditional representative of organized medicine~~, continue ~~the efforts it began in 1998~~ to oppose the use of the physician office medical record as a tool of the Health Care Financing Administration, as well as any other agency or third party to regulate the financing and practice of medicine; and be it further

RESOLVED, ~~That the AMA serve notice with passage of this resolution that the physicians of America are taking back the Medical Record and~~ That the ~~said~~ medical record shall be the sole property of the ~~patient and~~ physician and the information contained therein, the property of the patient ~~will be used solely to document the delivery of health care~~; and be it further

RESOLVED, ~~That the AMA develop a public education campaign to inform the American public on the importance of the confidentiality of the Medical Record~~. That the physician's office medical record should be used solely to document the delivery of health care.

AMA Action: Adopted as Amended Substitute Resolution 820 (w/change in title).

7. Resolution 821 – Evaluation and Management Codes

RESOLVED, That the AMA oppose the Evaluation and Management coding system being implemented by the Health Care Financing Administration, and be it further

RESOLVED, That the AMA develop a public education campaign to inform the American public of the E&M coding system in regards to the detrimental effects it will have on patient care.

AMA Action: Adopted Resolution 836 in lieu of Resolution 821 (See action taken under AMA Meeting Highlights).

1999 AMA Interim Meeting

Also in attendance from Oklahoma at this meeting were: Boyd O. Whitlock, MD, Tulsa, OSMA President, who also served as an Oklahoma Alternate Delegate; D. Robert McCaffree, MD, Oklahoma City, Delegate, American College of Chest Physicians; William O. Coleman, MD, Chair, OSMA-OMSS; Clarence Robison, MD, OSMA-OMSS Vice Chair; and Susan Paddack, AMA Alliance President-Elect. Medical Student Section members attending: Aaron Sapp, MSIV; Christine Kendrick, MSIII; Amy Matzell, MSIII; and Che Miller, MSIII.

The OSMA Delegation caucused each morning beginning Saturday, December 4 through Wednesday, December 8 to review resolutions and proposed House actions. The Delegation met on a daily basis (Sunday through Wednesday) with delegates from the states of Missouri and Arkansas, known collectively as the "Heart of America" (HOA) Caucus.

AMA Alliance Activities

Susan Paddack, AMA Alliance President-Elect, Ada, will be installed as the AMA Alliance President on Tuesday, June 13, 2000 during the AMA Alliance House of Delegates meeting.

Susan has been president, president-elect, first and second vice-president, regional vice president, and chair of the Health Projects and Long-Range Planning Committees for the Oklahoma State Medical Association Alliance.

Susan holds a Bachelor of Science in Education from the University of Colorado, and completed her Masters degree in Secondary Education at East Central University in 1993. She is currently employed as Director of Local Education Foundation Outreach for the Oklahoma Foundation for Excellence and also serves as adjunct faculty at East Central University. She is married to Gary Paddack, MD, a member of both the PLICO and OCVO Boards, who specializes in internal medicine. The couple has two children.

Meeting Highlights

Your OSMA Delegation and the members of the AMA House of Delegates deliberated over 70 reports generated by the AMA Board of Trustees, Councils, and Committees; as well as approximately 112 resolutions authored by state and specialty societies, AMA sections and commissions.

Significant actions taken by the AMA House include the following:

- E&M Documentation Guidelines. Adopted as Amended Substitute Resolution 813, reaffirming AMA policy 175.978 and calling on the AMA to take action to suspend Medicare prepayment audits. The resolution further calls on the AMA, if unsuccessful in these efforts, to ask HCFA to allow physicians to use the May 1999 proposed guidelines, as well as the 1995 and 1997 guidelines, and that the AMA immediately pursue legal and legislative action, including Congressional hearings, to force HCFA to stop prepayment audits.

- Dietary Supplements and Herbal Remedies. Amended current AMA policy in lieu of Resolutions 501, 505, 510, 516, and 520, calling for new measures to better educate the public and physicians about potential health impacts of herbal remedies, vitamins and dietary supplements.

- Pain Relief Promotion Act. Adopted as amended Substitute Resolution 215, which reaffirms AMA policy H-160.954; and directs the AMA to work with interested state and national specialty societies to improve Titles I and II of the Pain Relief Promotion Act of 1999 by deletion of those provisions which establish federal protocols and/or regulations for pain management and palliative care (including the proposed amendment to Section 502a of the Controlled Substances Act regarding educational and training programs for local, state, and federal personnel; Section 201 (a) (2) of the proposed Act regarding the collection and dissemination of protocols and evidence-based practices for palliative care; and any other such objectionable provisions of the proposed Act); and that the AMA will oppose any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

- Impaired Drivers and Their Physicians. Adopted CEJA Report 1, which contained seven (7) recommendations con-

cerning physicians' responsibility to recognize impairments in patients' driving ability that pose a strong threat to public safety and ultimately may need to be reported to the Department of Motor Vehicles (DMV).

- HCFA Interim Final Rule on the Use of Seclusion and Restraints. Adopted Substitute Resolution 101, which directs the AMA to formally oppose the HCFA Interim Final Rule as currently written, and establish principles for use in developing policy regarding restraints and seclusion, among which states that the use of restraints and seclusion is a medical decision and should not be dictated by government agencies.

- Allocation of Tobacco Settlement Funds. Adopted as Amended Resolution 421, which directs the AMA to quickly initiate discussions with appropriate national and state organizations and individuals about launching a multi-state effort to use ballot initiatives and other appropriate mechanisms to direct allocation of tobacco settlement funding consistent, to the extent possible, with AMA Policy H-490.924.

- Use of DNA Testing. Adopted as Amended Resolution 513, which directs the AMA to study the conflicts arising between the needs for collecting DNA samples for patient care versus the use of DNA information in the criminal justice system.

- Educating the American Public and Physicians About Physicians for Responsible Negotiations (PRN). Adopted as Amended Substitute Resolution 718, which directs the AMA to educate physicians and the American public regarding the benefits and advantages to be derived on their behalf from the activities of the PRN.

- Denied and Down-Coded Days. Adopted as Amended Resolution 716, which directs the AMA to seek legislation to eliminate the utilization of retrospectively denied (so-called "carve-out days") and down-coded days by managed care organizations, and disseminate information regarding this practice to physicians and their respective hospitals across the country in order to warn them and to help them fight the existence of denied and down-coded days which can be deleterious to patients' care; that the AMA make state medical societies aware of the problem of rampant and random utilization of retrospectively denied days by managed care organizations, and urge state medical societies to alert their respective attorneys general and state insurance commissioners.

OSMA Resolutions

The following specific actions were taken by the AMA House of Delegates on three resolutions introduced by the OSMA Delegation.

1. Resolution 6 - Guidelines regarding the Sale of Health Related Products from Physician Offices

RESOLVED, that physicians should provide health-related products such as ointments, medications, braces, etc., whenever it is cost efficient, time efficient, allows for earlier implementation of therapy, designed to minimize side effects of medication or equipment, and when it is financially cost efficient for the patient; and be it further

RESOLVED, that physicians, if called upon, should be ready to fully disclose the nature of any financial arrangement with the supplier or manufacturer in regards to these products; and, be it further

RESOLVED, that any dispensing of such materials should be governed by the axiom, "Is this good medicine?"

AMA Action: Reaffirmation of AMA Policy 140.931.

H-140.931 Sale of Health-Related Products from Physicians' Offices

"Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician.

Physicians who engage in-office sales practices should be aware of the related guidelines presented in Opinion 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices"; Opinion 8.03, "Conflicts of Interest Guidelines"; Opinion 8.032, "Conflict of Interest: Physician Ownership of Medical Facilities"; Opinion 3.01, "Nonscientific Practitioners"; Opinion 8.20, "Invalid Medical Treatments"; (see Appendix A) as well as the reports from which these opinions are extracted. The following guidelines stem from those opinions.

In-office sale of health-related products by physicians presents a financial conflict of interest, risks placing undue pressure on the patient, and threatens to erode patient trust and the primary obligation of physicians to serve the interests of their patients before their own. When these items offer some health-related benefits, the physician's influence over the sale is amplified and makes it even more necessary to place limits on such activities.

1. Physicians who do sell health-related products from their offices should not sell any health-related good whose claims of benefit lack scientific validity. Physicians should rely on peer-reviewed literature and other unbiased scientific sources that review evidence in a sound, systematic fashion when judging the efficaciousness of the product.

2. Physicians who sell health-related products from their offices should follow these guidelines to limit their conflicts of interest, minimize the risk of brand endorsement, and ensure a focus on benefits to patients. (a) Physicians may distribute health-related products to their patients free of charge or at cost, in order to make useful products readily available to their patients. When health-related products are offered free or at cost, it removes the elements of personal gain and financial conflicts of interest that may interfere, or appear to interfere, with the physician's independent medical judgement. (b) Except under certain circumstances, such as those described in Opinion 8.032, "Conflict of Interest: Physician Ownership of Medical Facilities," physicians should not sell a health-related good when patients can obtain a product that offers the same medical benefit at a local pharmacy or health-products store. (c) Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products. Disclosure includes informing patients of financial interests as well as about the availability of the product or other equivalent products elsewhere. Disclosure can be accom-

plished through face-to-face communication or by posting an easily understood written notification in a prominent location that is accessible by all patients in the office. In addition, physicians should, upon request, provide patients with understandable literature that relies on scientific standards in addressing the validity of the health-related good.

3. Physicians should not participate in exclusive distributorships of health-related products, in which the products are available only through physicians' offices and for which product there is no comparable alternative available at a local pharmacy or health-products store. Physicians should encourage manufacturers to make their products more widely accessible to patients (CEJA Rep. 1, A-99).

2. Resolution 414 - Tobacco Cessation Programs for Children

RESOLVED, that the AMA, together with the AAFP and other organizations, support health plan coverage for adolescents/children involving evidence-based approaches for FDA approved pharmacotherapy, and other treatments of smoking cessation.

AMA Action: Reaffirmed as current policy.

3. Resolution 611 - AMA Election Procedures

RESOLVED, that the AMA House of Delegates approve moving the candidate elections during the AMA Annual Meeting from Wednesday morning to Monday morning to allow candidates, their respective delegations and staff the ability to refocus their attention on the issues before the House and participate more fully in reference committee and House deliberations.

AMA Action: Adopted as Amended Substitute Resolution 613.

RESOLVED, That the American Medical Association House of Delegates ask the Council on Long Range Planning and Development and the Speaker to study the election process in the House of Delegates and report back to the House of Delegates by (I-2000).

Conclusion

- The AMA Delegation met at the OSMA Headquarters on Wednesday, January 5, 2000. The purpose of the meeting/conference call was for the Delegates to discuss what role(s) they should play (if any) in the face of a very serious movement for de-unification from the AMA at the 2000 OSMA Annual Meeting in May. The (AMA) Delegates essentially agreed to educate the OSMA Delegates about the benefits of unification and AMA membership, including the financial impact, and AMA's achievements on behalf of Oklahoma physicians. Some of the materials the Delegates agreed to use are the AMA's "Good News" packets, 1999 Achievements, 2000 Washington agenda and AMA's 2000 Member Reference Guides.

- The Delegates also discussed who would be speaking at the OSMA House of Delegates meeting in May. After much discussion the Delegates approved a letter be sent from OSMA President Dr. Boyd Whitlock to Dr. Ted Lewers, Chair, AMA Board of Trustees, requesting the presence of Dr. Tim Flaherty, Vice Chair, AMA Board of Trustees, at the OSMA House of Delegates meeting May 4-7, 2000.

- AMA Delegates and Alternate Delegates are meeting with their respective county medical societies to discuss AMA activities. Please take advantage of this valuable resource.

- The AMA Annual Meeting will be held June 11-15, 2000 in Chicago. Mary Anne McCaffree, MD, has been appointed to serve on Reference Committee D.

- On August 5, 1999, the AMA Delegation of the Kansas Medical Society withdrew from the Heart of America Caucus. Linda Warren, MD, chair of the Kansas AMA Delegation faxed a letter explaining their reasons (see Attachment II). Response (see Attachment III).

- During the Interim Meeting several members of the Heart of America met with the Kansas Delegation to discuss issues regarding their possible return to the Heart of America Caucus. A letter from the Kansas Delegation is attached for your reference (see Attachment IV).

On a personal note, I wish to express my sincere thanks to the OSMA Board of Trustees, my fellow Delegates and Alternates, Alliance members, and all of those members of the OSMA who supported me in my efforts for election to the AMA Board of Trustees. Although unsuccessful, we "fought the good fight" and I will continue to represent the best interests of Oklahoma physicians and our patients for as long as I have the privilege to serve as an AMA Delegate from Oklahoma.

Budget Request: $94,700

Respectfully submitted,
Jay Gregory, MD, Chair

ATTACHMENT I

Perry Lambird, MD, Memorial Resolution

Whereas, Perry A. Lambird, MD, sixty, a past president of the Oklahoma State Medical Association, and Oklahoma County Medical Society (Oklahoma City), died tragically on August 25, 1999 in an auto accident along with his wife Mona and daughter Jennifer, while vacationing in Turkey; and

Whereas, Dr. Lambird had faithfully served as a Delegate in this AMA House of Delegates for 18 years until the time of his death; and

Whereas, Dr. Lambird faithfully served the AMA as a member of the Council on Medical Service for nine years, including two years as its Chair (1991-1993); and

Whereas, Dr. Lambird, a pathologist, dedicated his entire professional life to his patients and the betterment of healthcare, serving as Chairman of the Medical Arts Laboratory in Oklahoma City, one of the southwest's largest and most respected laboratories; and

Whereas, Dr. Lambird may best be remembered by his friends and colleagues for his devotion to his profession as a tenacious and outspoken advocate in the AMA House on behalf of issues in which he strongly believed; therefore be it

RESOLVED, That the American Medical Association recognize Perry A. Lambird, MD, for his many years of distinguished service to organized medicine at the county, state, and national levels; and be it further

RESOLVED, That the American Medical Association House of Delegates extend its

heartfelt sympathy to Dr. Lambird's three surviving daughters (Allyson, Elizabeth, and Susannah) on the tragic loss of their father, mother, and sister.

ATTACHMENT II

Text of Letter Addressed to Jay Gregory, MD. Chair of the AMA Delegation, Explaining the Withdrawal of the Kansas Medical Society Delegation from Heart of America Caucus (dated August 5, 1999)

Dear Jay:
I am writing to you in my capacity as chair of the Kansas Medical Society's AMA delegation. After much reflection and discussion, our delegation has decided to withdraw from the Heart of America Caucus.

I would like to explain the reason for our decision, which was an exceedingly difficult one. We have nothing but the highest respect and affection for our colleagues in the states of Oklahoma, Missouri and Arkansas. We have all developed friendships and associations which would not have been possible without the opportunity to work so closely together at the AMA meetings. However, our delegation has become increasingly concerned with the emphasis and approach to the election process. While some attention to the election process is essential, in our delegation's view it receives much more emphasis than that with which we are comfortable. Our feelings in this regard have nothing to do with any individuals from the caucus who have been candidates for office. Rather, it has to do with our belief that there must be a balance between the emphasis placed on elections and issues. We feel the apparent direction of the caucus in the future will only place further emphasis on the elections aspect.

We are not critical of the desire of the caucus to become more aggressive in the election process. However, it is not the direction our delegation wants to take. We would welcome the opportunity to discuss our concerns with you or the other members of the caucus. We will continue to value the personal and professional relationships we have been so fortunate to enjoy through our affiliation with the Heart of America Caucus.

Sincerely yours,
Linda D. Warren, MD
Chair of the AMA Delegation

ATTACHMENT III

Text of Letter Authored by Perry Lambird, MD, AMA Delegate, Responding to Kansas Medical Society Delegation Withdrawal from the Heart of America Caucus (dated August 11, 1999)

Dear Linda:
Your letter of August 5 announcing that KMS was withdrawing from the Heart of America Caucus in the AMA House just arrived. I was a delegate when Oklahoma first began meeting with Kansas, and have truly enjoyed the associations and the people over the years.

It is probably not strictly correct to state that "some" attention to the election process is essential. We only have two duties in the House, to establish policy for the association and to elect those physicians upon whom we rely to execute the policy. Both of these items are worthy of consideration.

I personally came to the AMA House to establish the policy of the Association with respect to a number of issues—a cogent approach to the financing of medical care, clear support for practicing physicians as they confront daily challenges to their ability to render excellent medical care, and a unity of purpose. These are still my dreams.

What I have learned over the years is that we can be remarkably effective in establishing policy, big policy over several years of effort and "little" policy virtually instantaneously. It took ten years, but the AMA's approach to caring for the uninsured today is what originally came out of my word processor. The medical necessity provisions in current US legislative debate were authored here in Oklahoma. Upon reflection I am sure you will recognize literally reams of policy that were authored and pushed through by the Oklahoma-Kansas cabal and, subsequently the Heart of America caucus. We have debated, pled our cases, and succeeded. The Policy Compendium is filled with exemplary statements on virtually everything that affects American patients and their physicians.

But if we are so successful in establishing excellent policy, why are American medicine and the AMA both facing such dreadful futures?

The downside of serving in the House for a number of years is the recognition that policy without execution becomes merely mental self-flagellation. We elect individuals to Councils and the Board whose aims are NOT to execute the policy developed by the House but to become a paid near-retirement trustee or president of the AMA. Policy is effectively relegated to staff who, however dedicated, are simply not out on the front lines of medical practice. In fact, staff goals and physician goals may be totally contradictory. Rather than address and implement the policy of the House, Board members spend their time flying around the country at our expense on a continuous, Clinton-like campaign for their personal political goals.

From my years of service on the Council of Medical Service I am appalled at the lack of a long range legislative plan, a long range regulatory plan, or, for that matter, a vision of the future of medicine in any of its aspects. The Board does long range planning—but only for the AMA as an organization. It needs to be planning for medicine! Further, the Board is infinitely more attuned to staff than to the House or physicians. It is the staff that really decides who will be in a position to move up the ladder politically. Put an outstanding physician like Pam Formica (or Jerry Schenken or John Dawson) on the Board and they are sent to "represent" the association in Alaska and Puerto Rico. Board members who do not make waves "represent" us at the New York, California, Texas and Florida Medical Societies. This is a pattern dating well back into the Sammon's era and has continued non-stop.

All of which is why a number of us have concluded reluctantly that if we are to implement policy we must cobble together electoral support for candidates who wish to work for the House and its policies.

You, Jo Ellen, and I are the only three current delegates from the Heart of America caucus who have served on elective councils. Our last trustee was Hugh Rittez, almost two decades ago. Our last officer, if my memory serves me correctly, was nearly a half century ago (pre Anaheim reformation). Until this last election our visibility in the officer/trustee election process was nil. We cannot get ourselves or people who think like us elected if we do not organize politically. And that is one of our only two functions as delegates.

If you will recall, the election committee asked only for those who would volunteer to vote en bloc. We used on the numbers of those who did volunteer. Although we did not get Jay elected, we did establish true credibility as a caucus. A vote tally we put together at 11 PM on Tuesday night before the June election missed the anticipated vote counts by only 3 votes. We received the votes we anticipated and, chatting with other state campaigns, they received the votes we promised. All of this on a volunteer basis.

In looking through our two delegations there are some individuals who might make excellent candidates in the future IF we have an election mechanism to support them. Personally, I think this is supremely important. You know me as a policy wonk, and, I confess, I am one. But I am also woefully tired of elegant policy that is ignored by the Board and staff. We need to place some individuals in high AMA positions who will indeed reform the institution upon which we most heavily depend.

The letter I received was addressed to me personally. However, I have asked OSMA staff to send this reply to the other delegates and alternates from the Heart of America caucus. It would be my hope that, upon further reflection, Kansas would reup for at least another year. (In passing, I believe that it is Kansas' turn as host!) This would give us an opportunity to discuss the matters raised in both of our letters. It is likely that we really are not all that far apart.

Sincerely,
Perry A. Lambird, MD

ATTACHMENT IV

Text of Letter Addressed to Jay Gregory, MD, Chair of the AMA Delegation, Following Discussion of the Withdrawal of the Kansas Medical Society Delegation from Heart of America Caucus (dated December 6, 1999)

Dear (Jack, Pete, and) Jay:
I would like to express the thanks of the entire Kansas delegation for the opportunity to meet with the three of you to discuss issues relating to the Heart of America caucus yesterday. We all felt the discussion was positive and productive. We also felt that it might be helpful to you in reporting to your delegations for us to briefly summarize the issues we raised.

Our primary concern is that too much emphasis has been placed on AMA elections and the politics surrounding them, to the detriment of issues and policy discussions. At previous meetings we have expressed our distaste for block voting, an issue which seemed to put us at odds with the other delegations in the caucus. Because we spoke out against block voting, some members of our delegation felt their input was diminished or ignored on other issues. We have also been uncomfortable with the suggestion that caucus members take a more aggressive networking approach through small group dinners with delegates from other states. We have also felt that the tenor of discussion about certain candidates has been too personal and pointed at times.

Our concern with the emphasis placed on elections does not mean that we feel the process is unimportant. Rather, it reflects our strong belief that our first responsibility to our members back home is to help shape AMA policy. It is true that elections are also our responsibility as delegates. However, our members will judge our effectiveness (and AMA's, for that matter) on issues, not elections.

We are not critical of the caucus' desire to become more aggressive in the election process. However, it is just not a direction our delegation is comfortable with. We intend to spend this year focusing on how we can be most effective for our folks back home on the issues that are debated at the AMA. We continue to value the personal relationships we have with you and your delegations, and are grateful for the opportunity to express concerns with you.

Sincerely,
Linda D. Warren, MD
Chair, Kansas AMA Delegation

REPORT OF THE COUNCIL ON GOVERNMENTAL ACTIVITIES

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Richard J. Boatsman, MD, Chair
Referred to: Reference Committee III
(A-2000)

Introduction
The Council on Governmental Activities reviews federal legislation and regulations of concern to the medical profession or the health care industry, and initiates activities or undertakes appropriate responses on matters of priority interest. It also establishes and maintains relations with federal government entities having statutory or regulatory jurisdiction affecting the medical profession, the delivery of health care, or public health. In cooperation with any other Association councils and committees, it communicates with the medical profession, develops policy recommendation news for consideration by the Board of Trustees, and prepares testimony and otherwise conducts the federal legislative program of the Association. The activities of the Council are governed by the Association's Annual Program of Activities as defined and interpreted by the Board of Trustees.

Review of Activities
The full Governmental Activities Council met last year at the OSMA Annual Meeting in Tulsa on April 17, 1999. In addition to members of the Council, there were several special guests in attendance, including W.E. Watkins, MD, AMPAC Board member and Tim Flaherty, MD, from the AMA Board of Trustees. John Montgomery, OSMA's Federal Lobbyist, was also in attendance and presented an update of the news from Capitol Hill. He informed the Council that several health care reform bills would be introduced during the 106th Congress, and that the new Speaker of the House appears to be in tune with the concerns of the health care industry. John Montgomery also reported that he maintains contact with the Congressional Delegation's health aides so he can stay informed of the news on the Hill.

Conference Calls
The Council on Governmental Activities held two conference calls during the summer months. The first conference was held June 2, 1999, at the request of Congressman Coburn. He requested the OSMA's input on his Patient Protection bill. The bill was discussed at length and the Council made suggested revisions and forwarded the changes to Congressman Coburn. The bill was later withdrawn from consideration.

Another conference call meeting was held on June 29, 1999, with the purpose to discuss Senator Don Nickles' revised version of the *Pain Relief Promotion Act* of 1999. The Council agreed that this version was improved over last year's bill, but suggested a few minor changes. The Council agreed to endorse Senator Nickles' bill with inclusion of their changes. Additional information on this legislation is included later in this report.

Meeting with Senator Don Nickles
On July 7, 1999, representatives from the OSMA including Richard J. Boatsman, MD, Chair of the Council on Governmental Activities; Jack J. Beller, MD, Chair of OMPAC Board; Boyd O. Whitlock, MD, OSMA President; David Russell, MD, Chair, OSMA Board of Trustees; Brian Foy, OSMA Executive Director; and Kathy Musson, OSMA Director of Governmental Affairs, visited with Senator Don Nickles in his Oklahoma City office to discuss health care issues and to deliver a copy of the OSMA's letter supporting the "Pain Relief Promotion Act of 1999."

The Council Chair, Vice-Chair, and other officers and Executive staff planned

to meet in early November with Senator Don Nickles to discuss OSMA's position on the patient protection bills and other health legislation of interest to physicians. However, Senator Nickles, due to scheduling conflicts, had to cancel several meetings with the OSMA. To date, there hasn't been another meeting scheduled.

In addition, the Council Chair, Vice-Chair, various Council members and OSMA staff have been in constant contact with the AMA Washington office, the office of OSMA Federal Lobbyist John Montgomery, and the Oklahoma Congressional Delegation and their health staff for the past several months to discuss key issues of concern to physicians and patients.

Lucas Health Forum

On Monday, March 20, Representative Frank Lucas held a public forum to discuss health care and the role the federal government should play in providing health care to the American people. The free forum was held in Oklahoma City. Representative Lucas' office contacted the OSMA to seek its help in providing a physician member to participate on the small panel, and Dr. Richard Boatsman agreed to represent the Association. Several physicians, including OSMA leadership, attended the forum as well. The top priorities addressed at the forum included providing health care coverage to families without insurance and ensuring quality health care for rural areas.

Washington D.C. Trips
(listed in chronological order)

During May 1999, representatives from the OSMA went to Washington D.C. to visit the Oklahoma Delegation to discuss health care issues. Those traveling to Washington D.C. included: Richard J. Boatsman, MD, Boyd O. Whitlock, MD, Brian O. Foy, and Kathy Musson. John Montgomery joined Council representatives during the visits with the Oklahoma Delegation and their health aides. The Council provided members of the delegation with the OSMA's position on patients' rights legislation. They also sought support and co-sponsorship of the Quality Health Care Coalition Act of 1999, H.R. 1304 which would allow physicians to negotiate contract terms and conditions with health insurers.

AMA Grassroots Conference

The AMA Grassroots Conference was held on September 22-24, 1999, in Washington D.C. Those attending were: Boyd O. Whitlock, MD; Richard Boatsman, MD; David Selby, MD, Vice-Chair of the Council on Governmental Activities and AMPAC Board member; Kathy Musson; and John Montgomery. The conference provided leaders of the medical community from around the country the opportunity to receive the latest information on legislative issues of interest to physicians and patients.

Individual Visits to Washington, D.C.

Dr. Boatsman visited Washington D.C., at his own expense, again in April 2000 with the Lawton Chamber of Commerce. During his trip, he took time to visit with some of the Oklahoma Delegation's health aides about legislation of interest to Oklahoma physicians and patients.

Governmental Activities Vice-Chair David M. Selby, MD, representing the AMPAC Board of Directors, also made several trips to Washington, D.C. in early 2000. During those trips funded by AMPAC, Dr. Selby also visited with members of the Oklahoma Delegation and discussed legislation of interest to OSMA.

Current Status of Legislative Issues

Patients' Bill of Rights

The environment appears to have improved for passage of a patients' bill of rights, one of the OSMA's top priorities from the last few years. The issue proved to be a popular campaign theme for congressional candidates in the November elections and Congressional leaders have indicated that some form of managed care reform legislation will likely be advanced this year. In addition to patient protection legislation, medical savings accounts (MSAs) are also expected to be a part of the debate.

The House and Senate versions of patients' rights legislation are now being debated by a conference committee made up of appointed members of the House and the Senate. Official bipartisan conference activity began on Thursday, March 2, 2000. While the conference chairman, Senator Don Nickles, had hoped to be able to produce a bill for consideration prior to the Easter Recess (April 14 - April 25, 2000), it appears that the conference will be unable to meet this goal.

The AMA has urged Congress to produce a strong package of reforms to protect patients. Among the items called for by the AMA, and supported by the OSMA, are the following:

- Allow physicians to make medical decisions, not insurance companies.
- Hold health plans accountable when they make decisions that hurt patients.
- Allow patients an independent, timely appeal if care is delayed or denied.
- Ensure adequate choice of treating physicians, including specialists.
- Protect all Americans covered by managed care plans, not just some.

Additional talking points on Patients' Bill of Rights issues are included as Attachment I.

H.R. 1304, the "Quality Health Care Coalition Act of 1999"

The OSMA and the AMA continue efforts to obtain co-sponsors for H.R. 1304, the "Quality Health-Care Coalition Act of 1999" sponsored by Representative Tom Campbell and over 170 of his colleagues. Through its passage, self-employed physicians would be allowed to negotiate contract terms that protect patient confidentiality, increase patient choice, and improve quality of care. Currently, Representatives Ernest Istook, Frank Lucas, and Wes Watkins have signed on as cosponsors of the bill. Although Representative Tom Coburn, MD, had originally signed on as a cosponsor of the bill, he later withdrew his endorsement. The OSMA, in February 2000, signed on to a letter from the AMA to the House Judiciary Committee members. The letter, which was endorsed by more than 40 state medical associations, indicated the strong support for the bill and expressed clear preference for the legislation as opposed to alternatives supported by opponents of the bill which would limit the bill by adding provisions similar to legislation recently proposed in some states under the State Action Doctrine. The letter expressed that although legislation proposed under the State Action Doctrine is a crucial step in the right direction, the Campbell bill is the ultimate goal for improving the quality of health care for patients in this country.

Recently the U.S. House Judiciary Committee approved the bill. As of this writing, it appears that the bill will not be heard until after Easter recess. The Council will continue to seek support for this important legislation and also encourages all physicians to personally contact their member of Congress as well. A legislative alert (see Attachment II) and AMA talking points (see Attachment III) for antitrust relief are attached.

"Pain Relief Promotion Act" (S. 1272/ H.R. 2260)

During the Interim Meeting of the AMA House of Delegates held last December, perhaps the most highly profiled topic was the decision about whether or not the AMA should continue support of the *"Pain Relief Promotion Act"* (S. 1272/H.R. 2260),

authored by Senator Don Nickles, which would prevent the use of controlled substances in physician-assisted suicide while allowing physicians to aggressively treat pain. On the final day of the four-day gathering, a majority of approximately 500 delegates voted to support the federal bill. The OSMA has previously delivered a letter to Senator Nickles indicating our support.

The AMA asked the OSMA to assist in their efforts to work with Senator Nickles to clarify that progress in pain management and palliative care achieved at the state and local level will not be superceded by the federal bill and to further clarify that the federal government's role in the collection and dissemination of practice guidelines regarding palliative care does not include a federal role for the creation of guidelines. The OSMA has communicated these concerns with Senator Nickles' health staff. The OSMA also participated in several conference calls with the AMA during March 2000 to discuss proposed AMA draft amendments to the bill which were ultimately forwarded to Senator Nickles. The Council on Governmental Activities was polled to ascertain their support of the amendments, and the majority of the Council agreed to support the AMA amendments which were offered. An explanation of the provisions of the "Pain Relief Promotion Act" is included in this report as Attachment IV.

Recommendations

The Council on Governmental Activities encourages all physicians to become involved in the grassroots efforts to get to know their Congressman personally and to call on him when critical issues arise in Congress. In addition, the Council urges all OSMA members to contribute to the Oklahoma Medical Political Action Committee (OMPAC) and the American Medical Political Action Committee (AMPAC).

Conclusions

The Council on Governmental Activities will continue to work closely with the Oklahoma Congressional Delegation on issues of importance to physicians and their patients. The OSMA has a close working relationship with the members of the Oklahoma Congressional Delegation. We have access to all members of our Delegation and individual physician relationships with our U.S. Senators and U.S. Representatives are extensive.

John Montgomery, OSMA's Federal Lobbyist, has been very helpful to our efforts and will provide an update at a luncheon to be held on Saturday, May 6th which is being sponsored by the Council on Governmental Activities, the OSMA Council on State Legislation, and OMPAC. During the luncheon, OSMA physicians and Alliance members will receive updates on the Patients' Bill of Rights, antitrust legislation, and other issues being debated on Capitol Hill. Others participating on the federal panel, in addition to Mr. Montgomery, are Terry Carr, AMA Assistant Director of Congressional Affairs, and Cari O'Malley, AMA Regional Political Director. All physicians and Alliance members are encouraged to attend this complimentary luncheon; however, reservations are required.

Budget Request: $40,000

Respectfully submitted,
Richard J. Boatsman, MD, Chair

ATTACHMENT I

Patients' Bill of Rights Talking Points

Members of Congress on both sides of the aisle continue to express interest in advancing meaningful protections for patients in managed care settings. Multiple bills have been introduced.

The AMA believes that Congress should work in a bipartisan manner to implement:

Patient protections and plan disclosure requirements such as:

ensuring that the "medical necessity" of patient care based on "generally accepted standards of medical practice" rather than health plan definitions based solely on cost;

medically-based grievance and independent, third-party external appeals procedures for physicians and patients;

comparative information for patients and prospective enrollees on covered benefits, cost-sharing, service areas, physician and provider access (including access to specialists), and physician composition; nondiscrimination based on health status;

ban on gag clauses and gag practice in all plans;

"prudent layperson" standard for emergency services;

procedures to assure continuity of care for patients and access to specialty care;

prohibition on incentive arrangements to limit medically necessary care to patients; and

health plan accountability so that health plans would be liable for negligent medical decision-making regarding denial of covered services.

establishing a floor, not a ceiling, and not preempt stronger state patient protection statutes.

ATTACHMENT II

Legislative Alert: Antitrust Legislation

On Thursday, March 30, 2000, in a tremendous victory for patients and physicians, the U.S. House Judiciary Committee approved H.R. 1304, "The Quality Health Care Coalition Act of 1999," sponsored by Rep. Tom Campbell and 211 of his colleagues by a vote of 26-2. Rep. James Sensenbrenner (R-WI) and Rep. George Gekas (R-PA) were the only two members of the House Judiciary Committee to oppose the bill.

This landmark antitrust relief legislation would level the playing field between enormous health plans and individual patients and physicians. The bill would allow physicians to come together to negotiate with health plans over contract provisions, so physicians could continue to fulfill their role as patient advocates. The final bill that will go the House floor contains four amendments supported by the AMA.

All references to any federal plans (i.e., Medicare/Medicaid) were removed in an effort to keep the bill alive.

Only three of Oklahoma's Representatives have signed on to this legislation. They are: Wes Watkins (District 3); Ernest Istook (District 5) and Frank Lucas (District 6). *Representative Tom Coburn had originally signed on to the bill as a cosponsor but has since removed his name.*

This bill could be heard by Congress as early as next week; although may not be heard until after Easter recess. It is important that all of the Oklahoma Delegation hear from physicians from their districts to encourage their support, or continued support of this important legislation.

Steve Largent (District 1)	(202) 225-2211
Tom Coburn (District 2)	(202) 225-2701
Wes Watkins* (District 3)	(202) 225-4665
J.C. Watts (District 4)	(202) 225-6165
Ernest Istook* (District 5)	(202) 225-2132
Frank Lucas* (District 6)	(202) 225-5565

* Currently listed as cosponsors of HR 1304.

Call your Congressman this week and let him know that you support passage of H.R. 1304, "The Quality Health Care Coalition Act of 1999," sponsored by Rep. Tom Campbell. Attached are talking points to help you with this effort.

ATTACHMENT III

AMA Talking Points:
Antitrust Relief Needed
Updated points for the second session of the 106th Congress

The Problem:
Six giant health insurance companies now control the health care market place. These plans control quality, cost and access to health care. The increased consolidation of health insurers means that physicians are given little or no opportunity to advocate for the best care of their patients.

The sheer size of these insurers, who often put profits over patients, allows them to use **strong-arm tactics** on health providers. These tactics mean that HMOs, not doctors, are dictating health care. Unfair antitrust laws compound the problem. These laws undermine the ability of physicians and other health care providers to advocate for their patients through contact negotiations.

What do the Insurers' Strong-Arm Tactics Mean for Patients?
Patients suffer because physicians are forced to sign "take-it-or leave-it" contracts with these all-powerful health plans.

Take-It-or-Leave-It Contracts Dictate the Practice of Medicine by:

- **Forcing** patients to accept the cheapest care. Patients are often forced by a plan to accept the least expensive form of treatment even if such care is contrary to a physician's recommendation.
- **Preventing** patients from learning about the broad range of treatment options. Health professionals are often barred from informing patients of an alternative treatment if the health plan does not cover such a procedure.
- **Releasing** confidential patient information. Plans can release confidential information without patient consent while simultaneously shielding themselves from liability, leaving the patient without redress.
- **Forcing** unreasonable rules and restrictions on physicians even if they lead to inadequate care for patients.

The Solution:
H.R. 1304, the "Quality Health-Care Coalition Act of 1999" sponsored by Representative Tom Campbell and over 175 of his colleagues.

H.R. 1304 would allow PATIENTS and their physicians, not insurers, to make informed decisions about the patient's health care needs.

- **How?** Self-employed physicians would be granted a limited ability to negotiate with health plans. Thus, physicians would be allowed to negotiate contract terms that protect patient confidentiality, increase patient choice and improve quality of care.
- **H.R. 1304** would level the playing field. HR 1304 would restore balance in the market by increasing physicians' power to negotiate for their patients against the BIG SIX.

ATTACHMENT IV

American Medical Association's Position on the "Pain Relief Promotion Act of 1999" S. 1272/ H.R. 2260 — introduced by Rep. Don Nickles and Rep. Henry Hyde

Q: *What does the bill do?*

A: The bill would add a provision to the Controlled Substances Act (CSA) acknowledging the legitimate medical purpose of controlled substances in the management of pain or discomfort, even if their use increases the risk of death for the patient (the so-called "double effect").

The bill states that, as a matter of federal law, any State law authorizing or permitting assisted suicide or euthanasia would be "without force and effect" in implementing the CSA.

It would provide for education and training programs for law enforcement personnel regarding the legitimate and necessary use of controlled substances in pain management. It would also authorize the Agency for Health Care Policy and Research to collect and disseminate protocols and evidence-based practices regarding palliative care, as well as provide for grants from the Department of Health and Human Services for the development and implementation of health professionals' training in palliative care.

Q: *What is the AMA's position on the bill?*

A: The AMA supports the bill, but will continue working with the sponsors to strengthen the education and training provisions and to assure that the development of such programs includes input from physicians regularly engaged in pain management practice. The AMA has long-standing policy strongly opposing physician-assisted suicide.

Q: *The AMA opposed last year's "Lethal Drug Prevention Act." How is this year's bill, the "Pain Relief Promotion Act," different?*

A: The addition of language explicitly acknowledging the medical legitimacy of the "double effect" in the CSA provides a new and important statutory protection for physicians prescribing controlled substances for pain, particularly for patients at the end of life. This significant improvement to the CSA largely rectifies the AMA's concern about last year's bill regarding the potential to chill appropriately aggressive prescribing for pain management.

The "Pain Relief Promotion Act" takes a different approach regarding the DEA's role than last year's bill. Last year's bill cited participation in physician-assisted suicide as a reason to revoke a physician's DEA registration, and specifically permitted revocation or denial of registration if the DEA believed there was reason to suspect a physician's intention was to assist a suicide. This year's bill changes its approach by focusing on whether the State (Oregon) law is, in itself, in the "public interest." The current CSA includes "compliance with applicable State or local law" as a factor to be considered in evaluating whether a DEA registration or application for registration is consistent with the public interest." The bill would allow the Attorney General to behave as though the Oregon Death with Dignity Act simply does not exist.

Q: *Does the bill create any new or additional criminal penalties for physicians?*

A: No. The bill would not expand existing criminal penalties in the CSA for persons whose unauthorized use of a controlled substance leads to someone's death (21 USC 841 (b)). Nor would it change the definition of what would be a "prohibited act." Nor would it change the intent standard to establish that a

prohibited act had occurred. In fact, as noted above, it would add a new statutory protection for physicians that would acknowledges that legitimate medical use of controlled substances to help alleviate or control pain may, as a secondary effect, hasten death.

Q: *What is the effect on the Oregon Death with Dignity law?*

A: While the bill would not technically "overturn" the Oregon law, it would severely hamper the ability of patients to invoke it, since physicians would be unable to legally prescribe intentionally lethal doses of federally controlled substances. It has been pointed out that substances other than those controlled by the CSA might still be available for physicians seeking to assist a suicide under the Oregon law.

Q: *What is the effect on Oregon physicians?*

A: Oregon physicians will be precluded from prescribing or using controlled substances to help their patients commit suicide under the terms Oregon Death With Dignity law. The bill is not retroactive, so physicians who have previously legally assisted a suicide under the Oregon law would not be affected.

Q: *What is the effect on physicians in the other 49 states?*

A: The bill would not expand the DEA's authority concerning jurisdiction, investigations or enforcement regarding the CSA. In fact, the inclusion of a recognition of the "double effect" in the CSA provides physicians in all jurisdictions an additional statutory protection in cases of alleged PAS. The bill has the potential, through its educational provisions, of sensitizing law enforcement personnel to the multiple issues of end-of-life care and prescribing.

Q: *Isn't there a constitutional problem with this approach?*

A: We anticipate that some will challenge the bill on constitutional grounds, based on the implicit conflict between state and federal law. Whether the federal government can proceed in the implementation and enforcement of its laws by explicitly ignoring — rather than preempting — state law is a matter for the courts to decide. This potential conflict does not affect the AMA's policy position regarding the substance of the bill.

Q: *How do you reconcile the AMA's position on Hyde-Nickles with your policy opposing criminalization of physician practice, like in the partial-birth abortion bill?*

A: The bill does not add any new criminal penalties for physicians under the Controlled Substances Act. The DEA *currently* has the authority to investigate doctors prescribing controlled substances and to impose criminal penalties if they are prescribing those drugs in a manner inconsistent with legitimate medical practice.

We see the bill as providing a *new statutory protection* for physicians who aggressively prescribe controlled substances to help patients in pain at the end of life. We never had that before. And this bill provides that. So we see it as *reducing* physicians' exposure to criminal investigation and prosecution for legitimate medical practices.

■ REPORT OF THE INTERNATIONAL MEDICAL GRADUATE COMMISSION

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Kautilya Mehta, MD
Referred to: Reference Committee III (A-2000)

Introduction

The Commission on International Medical Graduates (IMG) was organized as a liaison to the Oklahoma State Medical Association on matters impacting all international medical graduate physicians practicing in Oklahoma.

Review of Activities

Two IMG Commission members, Doctors Kautilya Mehta and Mukesh Parekh, represented the OSMA at the IMG Section of the American Medical Association meeting in Chicago in June 1999. Dr. Mehta was nominated for a position on the AMA's IMG Section Governing Council. Only four slots were open this year for the 1999-2000 Governing Council. Although Dr. Mehta did not win a slot on the Council this year, his leadership and involvement with IMG issues through the years is well known by physicians around the country.

The principal issues debated in the IMG Section Assembly were the IMG role in governance of the Educational Commission on Foreign Medical Graduates (ECFMG), physician retraining needs in the context of physician workforce planning, and formation of a national collective bargaining organization. The defining issue for the AMA at this meeting (and well into the future) was collective bargaining. The IMG Section Assembly adopted language parallel to that of the other AMA constituencies, supporting the AMA's development of a bargaining unit for employed physicians and residents.

OSMA's IMG Section submitted AMA Resolution 314 - Licensure of IMGs, which was approved as amended by the AMA House of Delegates in June 1999. This resolution requested the AMA to ask the Federation of State Medical Boards to urge all state licensing boards to adopt a fair and uniform standard governing the number of administrations of licensure examinations. Council members agreed that a resolution similar to Resolution 314 should ideally be submitted to the OSMA House of Delegates at some point in the future. However, efforts to educate OSMA leaders need to be made first so they will become aware of the barriers to licensure which face international medical graduates. One example is that an American medical graduate learns about the United States Medical Licensing Examination (USMLE) as soon as they enter medical school and knows they will have only three attempts to pass the exam, whereas this information is not available to the international medical graduate.

Other resolutions introduced by the AMA IMG Section which were adopted by the AMA House of Delegates are as follows:

Resolution 324, asking the AMA to consider physician retraining during its deliberations on physician workforce planning, and that they do a survey of all US residency programs to identify the number of physicians undergoing specialty training in order to assess the extent of physician retraining needs, with a report back to the HOD by A-2000; and Resolution 616, asking the AMA to develop a procedure by which special interest physician groups such as the IMG/ethnic medical societies may apply for admission to the House of Delegates.

A major issue the Council is attempting to address is to fill vacant positions in the residency programs at the University of Oklahoma with eligible IMGs. Since the Oklahoma Board of Medical Licensure and Supervision (OBMLS) has enacted a rule that any candidate who has more than three attempts at any of the licensing examination

(United States Medical Licensing Examination [U.S.M.L.E.] Step 1, 2 or 3) or more than six total attempts, then he or she will not be granted even a special training license (required for residency training); this will prevent many of the good candidates from getting into residency training programs. Dr. Mehta and Dr. Ramgopal met with the OBMLS Board; however, the OBMLS is not likely to change this rule.

The Mini-Externship Program established in 1998 is proving beneficial and has been well received. Sixteen international medical graduates have participated thus far, and several more have completed applications and are waiting to be matched with sponsors. There continues to be a problem with some Tulsa hospitals that will not allow IMGs to observe sponsoring physicians. The Council has asked OSMA President, Boyd O. Whitlock, MD, to intervene and contact hospital administrators or medical directors to explain the program and seek their cooperation.

Conclusion
The Commission on International Medical Graduates will continue to provide outreach and a communication vehicle between the OSMA and IMGs, work on increasing OSMA IMG membership, and represent OSMA IMGs in the AMA House of Delegates.

Budget Request: $2,650

Respectfully submitted,
Kautilya Mehta, MD, Chair

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CONSENT CALENDAR
Subject: Annual Report
Presented by: Roger E. Sheldon, MD, Chair
Referred to: Reference Committee III
(A-2000)

Introduction
The OSMA Council on Medical Education studies and makes recommendations related to all matters of maintaining or improving the level of medical competency in Oklahoma, including but not limited to: maintaining liaison with other emerging health professionals or occupations, and to accrediting medical education providers in Oklahoma. The Council also monitors CME standards, as they may be required by Association policy.

Review of Activities
The Council on Medical Education met on July 29, 1999, September 30, 1999, January 25, 2000, and March 2, 2000. Since the last report to the House of Delegates (1999) the Council has approved the following:

Site Surveys
Integris Baptist Medical Center – three-year full accreditation
*Integris Bass Memorial Hospital – two-year provisional accreditation
Mercy Health Center – three-year full accreditation
Norman Regional Hospital – three-year full accreditation
St. Johns Medical Center – four-year full accreditation
*Shawnee Regional Hospital – two-year provisional accreditation
*OSMA Education & Research Foundation – two-year provisional accreditation

*highest status that can be granted to first-time applicants

Interim Reports
Integris Southwest Medical

Pre-applications
Woodward Hospital

Other Business
New System of Accreditation
The OSMA Council on Medical Education has reviewed the new System of Accreditation by the Accreditation Council for Continuing Medical Education (ACCME) and as required by the ACCME the OSMA has incorporated the same and in some instances stricter essential areas, elements and criteria for evaluation into their accreditation programs.

The OSMA Board of Trustees approved the new system of accreditation, as well as the fee structure, at the February 6, 2000, meeting.

A proposed time frame of January 2000 for the adoption of the new essentials, policies, and application with implementation of such a system by January 2001.

The Council approved the following revised items:
OSMA Policies & Procedures
OSMA Essential Areas
OSMA Application for Accreditation
Site Survey Report Form

These reformatted documents do not materially change the requirements placed upon a sponsor to gain or maintain accreditation. The application and site survey forms are reorganized to correspond to the newly reorganized essential areas. The policies and procedures reflect all of the old policies, but are reformatted to mesh with the ACCME's new approach.

Due to the length of the documents, a copy will be provided to the Reference Committee Chairman and made available upon request to any OSMA member.

OSMA Accreditation Fee Structure
The OSMA Council on Medical Education met September 30, 1999, to review the current fee structure for the OSMA recognition program. Below you will find the approved fee increases which will be implemented in July of 2000. These fees are necessary to keep our program budget neutral.

The Council has been given the authority to set fees, and would like to submit the new fee structure to the House for specific concurrence because of the sensitivity of fees and charges. Since we are no longer an entity of the OSMA Education & Research Foundation these fees are structured in order to support the estimated expenses of the Council.

The Council also discussed the need to develop and implement an annual report for accredited providers. This annual report will replace the interim report currently being utilized and a fee of $250 will be charged. This fee will partially offset the administrative costs of the services provided by OSMA which include:

CME Update - newsletter printed quarterly;

Unlimited support services provided by OSMA staff; and

CME course schedules of OSMA accredited providers printed monthly in the OSMA *Journal*.

Fee structure recommendations:

Application	$1,200
current fee is $1,000	
Annual	$250
new fee	
Pre-App	$200
no change	
Surveyor Honorarium	$300
current honorarium $250	

OSMA Council on Medical Education Accredited Institutions
The OSMA CME office has mailed 8 pre-applications to prospective institutions seeking OSMA accreditation. Of the 8 pre-applications mailed, two were approved by the Council and application materials were mailed. The Council accredited three new institutions this year: Integris Bass Memorial Hospital, OSMA Education &

Research Foundation, and Shawnee Regional Hospital.

Deaconess Hospital
Norman Regional Hospital
Duncan Regional Hospital
Orthopaedic & Reconstructive Research Foundation
Hillcrest Medical Center
OSMA Education & Research Foundation
Institute for Mental Health
Shawnee Regional Hospital
Integris Baptist Medical Center
St. Anthony Hospital
Integris Bass Memorial Hospital
Saint Francis Hospital
Integris Southwest Medical Center
St. John Medical Center
Jane Phillips Medical Center
Stillwater Medical Center
Mercy Health Center
Valley View Regional Hospital

Oklahoma Alliance for Continuing Medical Education (OkACME)
The Council was active in the support of the OkACME spring conference held June 4, 1999, in Oklahoma City. Murray Kopelow, MD, ACCME Executive Director, as well as Bruce Belende, Executive Director of the Alliance for Continuing Medical Education, presented information regarding System 98, the new CME accreditation system. Dr. Roger Sheldon, as well as Brian Foy and Barbara Matthews, presented information for new institutions interested in seeking accreditation. OSMA sponsored the conference with an unrestricted educational grant.

OSMA Accreditation
In March of 1999 the ACCME's Committee for Review and Recognition (CRR) approved the OSMA for recognition for a period of four years with a progress report in one year. The OSMA completed the progress report in January of 2000. The Council has been notified of the approval of the progress report by the ACCME (see Attachment I).

Recommendations
- Approval of the revised system of accreditation:
 OSMA Policies & Procedures
 OSMA Essential Areas
 OSMA Application for Accreditation
 Site Survey Report Form

- Approval of the increased fee structure.
 Application $1,200
 current fee is $1,000
 Annual $250
 new fee
 Pre-application $200
 no change
 Surveyor Honorarium $300
 current honorarium $250

Conclusions
The Council on Medical Education continues to meet via video teleconferencing through the campuses of the OU College of Medicine-Oklahoma City and the OU College of Medicine-Tulsa. This allows a larger attendance and better interaction between both sites.

Budget request: $9,363
Anticipated revenue: $10,850

Respectfully submitted,
Roger E. Sheldon, MD, MPH, Chair

ATTACHMENT I

Text of Letter Addressed to Roger Sheldon, MD, Chair of the Council on Medical Education, Giving Notice of Approval of Progress Report (dated March 9, 2000)

Dear Doctor Sheldon:
The Committee for Review and Recognition (CCR) met on March 4, 2000 to review the Progress Report prepared by the Oklahoma State Medical Association to address the deficiencies that were identified at the time of your last survey. The Committee voted to accept the report, indicating that all deficiencies were resolved.

Thank you for your efforts to sustain and improve your accreditation activities. Should you have any questions, please do not hesitate to contact us.

Sincerely,
Murray Kopelow, MD
Executive Director

REPORT OF THE COMMITTEE ON MEDICAL ETHICS AND COMPETENCY

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Jay A. Gregory, MD, Chair
Referred to: Reference Committee III
(A-2000)

Introduction
The Committee on Medical Ethics and Competency has been given the responsibility of investigation, deliberation, and deposition of complaints regarding OSMA member physicians. In addition the Committee has expanded its scope of services to physicians to become a resource to members on issues relating to medical ethics.

Review of Activities
The Committee on Medical Ethics and Competency met on October 26, 1999, at OSMA Headquarters. Jay A. Gregory, MD, chaired the meeting. Those attending included: James Claflin, MD; Mary Gumerlock, MD; Brian O. Foy, OSMA Executive Director, and teleconferencing: Boyd O. Whitlock, MD; and David M. Selby, MD.

The Committee reviewed and took action on patient complaints received from January 1998 to present. The Committee members reviewed current policy and procedures and concluded that complaints received regarding rural county physicians should first be directed to the Committee Chair for review and appropriate action. All complaints regarding physicians in Oklahoma or Tulsa counties are, as a matter of routine, referred to those respective county medical societies for review and action as appropriate.

The Committee discussed the possibility of becoming a resource to OSMA members on medical ethics issues. Currently, there is no organizational entity within OSMA charged with discussing matters relating to medical ethics. The Committee felt that this would be an appropriate expansion of its service to members and further allow the Committee to be a resource to the Board of Trustees in the development of OSMA policy on ethical issues. Articles were prepared for the OSMA newsletter and *Journal* informing the membership of the resource.

On Thursday, February 3, 2000, Jay A. Gregory, MD, Chair, reviewed and took action on 10 open cases. The Committee has reviewed and closed 33 of the 45 cases received since May 1999.

Conclusions
The Committee on Medical Ethics and Competency will continue its activity in the review of physician complaints and stands ready and able to serve our members on issues of medical ethics.

Respectfully submitted,
Jay A. Gregory, MD, Chair

REPORT OF THE COUNCIL ON MEMBER SERVICES

FILED FOR INFORMATION
Subject: Annual Report
Presented by: David Nierenberg, MD, Chair
Referred to: Reference Committee III
(A-2000)

Introduction
The various programs of the Member Services Council are designed to encourage participation and membership in the Oklahoma State Medical Association. The products and services offered should provide quality and value to the Association members and when possible, provide a source of non-dues revenue to the Association at no expense or detriment to the membership. Various endorsements also provide advertisement in our *Journal*, the *Directory of Physicians*, and exhibit fees and sponsorships at the OSMA Annual Meeting.

Financial Report
The Member Service Corporation produced a net profit in non-dues revenue of $7,487 during 1999, added to the existing balance of $25,491. To assist with OSMA operating funds, $20,000 will be moved to the 1998 OSMA accounts. The Member Services Corporation accounts will be left with a balance of $12,978 after the transfer of funds is made.

Review of Activities
Your Council on Member Services met in February, July, and November of 1999. Also attached to this report is a breakdown of the activities of the various "preferred vendors" during 1999. The Council reviewed the current vendors and decided to discontinue the endorsement of three to lack of interest/use: Quest Destinations Program, Conomikes Reports, and LDS Communications.

New Business
Specialty Billing Services
Specialty Billing Services became a preferred vendor in August of 1999. SBS offers a free one-day office consultation to analyze existing accounts receivable to OSMA members. Established in 1993, the company's goal is to provide complete, comprehensive billing services to both hospital-based and private practice physicians throughout the state. With the increased demands of managed care and insurance contract requirements, insurance billing has become a time-consuming process that is often too difficult for the average-size office to maintain.

Global Members Purchasing System (GMPS)
GMPS is an independent distributor of office supplies, computer and medical supplies, business forms, printing promotional products, filing systems, etc., and offers you:
- Guaranteed savings on each order.
- Free ground freight on all orders.
- A single source for all your supply needs (including paper goods, cleaning and hygienic supplies, uniforms, patient charts, indexes, labels, etc.).

GMPS currently provides purchasing services for over 65,000 members nationwide.

Headquartered in Orlando, Florida, GMPS has offices and warehouse facilities throughout the United States. Special features of their services include:
- A full support staff, providing nationwide coverage for all aspects of the program.
- If a product or special item is not in stock (GMPS will locate it for you).
- Exclusive toll free numbers to facilitate ease of ordering: Phone: 800/459-7387 Fax: 800/203-3119.
- Open account status available immediately to members of OSMA.
- Web site address is www.agpsave.com for ordering online.

GMPS delivers quality products in a timely fashion, at a guaranteed savings to our members.

The Council on Member Services has researched the following vendors to ensure they are reputable and competitively priced. Many of the preferred vendors offer essential services that are needed by OSMA members. These services also provide revenue for the OSMA.

OSMA Preferred Vendors
AutoFlex Leasing: AutoFlex Leasing is located in Dallas, Texas, and is recommended by several state medical associations. It offers very competitive prices and services to physicians that lease or purchase automobiles. They will arrange to pick up and deliver anywhere in the state of Oklahoma for OSMA members.

C.L. Frates and Company: OSMA recommends the following insurance programs offered by C.L. Frates and Company: Business Overhead Expense; Disability Income; Group Term Life: Hospital Indemnity; Accidental Death and Dismemberment; High Limit Term Life, and Workers Compensation Plan.

Global Members Purchasing System: GMPS is an independent distributor of office supplies, computer and medical supplies, business forms, printing promotional products, filing systems, etc., and offers you:
- Guaranteed Savings on each order.
- Free ground freight on all orders.
- A single source for all your supply needs (including paper goods, cleaning and hygienic supplies, uniforms, patient charts, indexes, labels, etc.).

GMPS currently provides purchasing services for over 65,000 members nationwide. Headquartered in Orlando, Florida, GMPS has offices and warehouse facilities throughout the United States. Special features of their services include:
- A full support staff, providing nationwide coverage for all aspects of the program.
- If a product or special item is not in stock (GMPS will locate it for you).
- Exclusive toll free numbers to facilitate ease of ordering: Phone: 800/459-7387 Fax: 800/203-3119.
- Open account status available immediately to members of OSMA.
- Website address is www.agpsave.com for ordering online.

Harrison Peck & Associates, PC: Harrison Peck & Associates has developed a wide scope of services to respond to the changing needs of their clients, including coding analysis, billing services, and practice management. Harrison Peck Associates provides initial telephone consultations to OSMA members at no charge. If the member needs additional services, Harrison Peck will make an on-site conference visit to discuss the consulting services available and financial obligations at that time.

I.C. Systems: I.C. Systems is a nation-wide accounts receivable management company that provides collection services to clients in all 50 states. Established in 1938, I.C. Systems has grown to be one of the largest privately-owned collection agencies in the country, noted for its ethical and progressive services.

James Baker & Associates: James Baker & Associates, created in 1979, is one of the largest independently owned investment services firms domiciled in the state of Oklahoma. The firm purposefully designed an OSMA investment program to offer nonpension investment services to members that are unique from other large brokerage firms, trust departments, and financial planners. JBA will travel to anywhere in Oklahoma to meet with OSMA members to present a personalized investment evaluation, offering members a confidential relationship with a disciplined investment strategy tailored to the member's goals, objectives, and tax considerations.

MBNA: Through a special arrangement with MBNA America Bank, one of the nation's largest issuers of affinity credit cards, OSMA offers to its members an Oklahoma State Medical Association MasterCard credit card program. The card offers a low introductory annual percentage

Survey of Vendors/Services

Vendor	Service Provided	Non-Dues Revenue Accrued in 1999/00	Contract Began	Contract Ends	Participation by OSMA Members during 1999
AutaFlex	Automobile Leasing/Purchase	$1,000	01/1996	12/2001	2 Leases
C.L. Frates and Company	Insurance	$6,000	01/1993	12/2003	
				Plan	New Policies in 1999 / Policies to Date
				Business Overhead	7 / 114
				Disability Income	11 / 202
				Group Term Life	18 / 210
				Hospital Indemnity	0 / 47
				Accidental Death	0 / 72
				High Limit Term Life	8 / 52
Canomikes Reports, Inc	Publications/Medical	$157	N/A	Open-Ended	
Destinations - Quest Program	Travel Discounts on Car Rentals, Restaurants, Hotels	$389	03/1994	Open-Ended	OSMA Quest Members 122
Harrison Peck & Associates PC	Consultation/Practice Management	N/A	03/1992	Open-Ended	20-25 referral calls, 6 billable projects
I.C. System, Inc.	Collections	$1,850	09/1986	Open-Ended	
James Baker & Associates	Non Pension Investment Portfolio Management	N/A	02/1999	Open Ended	
LDS Communications	Long Distance Service/Internet Access	$484	06/1997	06/1998	
MBNA	Banking/Credit Card Program	$5,000	11/13/97	11/13/2002	159 accounts
Oklahoma Centralized Verification Organization	Credentials Verification	0	08/1996	08/2001	Processed over 7,000 applications including both the initial application process, as well as the centralized reappointment program.
PLICO	Liability Insurance	PLICO contributes a substantial amount to OSMA each year. (See PLICO Report to Board of Trustees)	OSMA owns PLICO	N/A	4,200 Insureds (MDs & DOs)
PLICO Health	Health Insurance	N/A	OSMA owns PLICO Health	N/A	
ToxResource	Consultation/Tax Audit	$2,235	12/1995	Open-Ended	Total Memberships 131
Travel the Continents (TRAVCON)	Travel	$1,995	08/1996	Open-Ended	
Utica Physicians' Association, Ltd (UPAL)	OSMA Group Pension Program	$1000	01/1993	01/1998 (up for renewal)	

Survey of Vendors/Services (continued)

Vendor	Service Provided	Non-Dues Revenue Accrued in 1999/00	Contract Began	Contract Ends	Participation by OSMA Members during 1999
Oklahama State Medical Assaciatian	Seminars/ Vendar Endarsement	Approximotely $7,487	N/A	N/A	*"Basic Cading far Physician Services"* 20 attendees in Oklohama City, 12 attendees in Tulsa, January 7 & 14, 1999. *"Evaluatian & Management Cading and Dacumentatian"* 27 attendees in Oklahama City, 10 attendees in Tulsa Jonuory 7 & 14, 1999. *"Computers Made Easy"* Limited seating: 19 attendees in Oklahama City, 17 in Tulsa February 10-11, 1999. *"Basic Cading far Physician Services"* 10 attendees in Stillwater February 19, 1999. *"Intraductian ta the Web"* Limited seating. 16 attendees in Oklahama City, 15 attendees in Tulsa February 24-25, 1999. *"Managing Managed Care"* Scheduled far Oklahama City on March 24 and Tulsa an March 31, 1999. *"Campliance Pragram-Legal Intraductian"* Scheduled far May 20 in Tulsa, May 22 in Oklahama City, ond May 27 in Ardmare. *"Basic Cading far Physicians Services"* Scheduled for June 1999 in Oklahama City and Tulsa. *"Office Pracedures"* Scheduled far August 1999 in Oklahomo City and Tulsa. *"Internal Cantral far the Medical Office"* August 24 in Oklahoma City: 7 attendees; September 3 in Tulsa: 10 attendees. *"Investment Management far the New Millennium"* Rescheduled twice but cancelled due ta na/low respanse. *"Cammunicatians far Physicians, Emplayees, and Public Relatians"* October 12 in Tulsa: 8 attendees; October 14 in Oklahama City: 12 attendees. Nate: Handouts are generally provided at each af the seminars.

rate for balance transfers and cash advance checks. Once you receive the card, OSMA receives a contribution from MBNA. Each year your account is renewed and every time you make a purchase, MBNA makes another contribution to OSMA.

Oklahoma Centralized Verification Organization (OCVO): The OCVO offers an excellent service for OSMA members in that it centralizes the completion of applications for all the various managed care organizations and hospitals.

PLICO: The Physicians Liability Insurance Company provides recommended professional liability insurance to OSMA members. PLICO has been formed to provide an economical alternative to the commercial insurance industry. Through PLICO, state physicians will continue to enjoy unique benefits, high-quality coverage, program stability, and premium savings they have maintained for some thirty-five years through the pooling of their professional liability insurance resources into a single company.

PLICO Health: Available only to members of the OSMA, their employees, and families. The PPO was created as a cost effective alternative to traditional health insurance. Guaranteed coverage means that insurance is provided without evidence of incurability, a pre-existing condition exclusion, or participation requirements. Four deductible and co-pay options are offered.

TaxResource: TaxResource is an organization that provides representation to physicians in the event of an IRS tax audit. They provide full on-site services, plus newslet-

ter and telephone consultation for a yearly membership fee for both personal and business programs.

Travel the Continents: TravCon-Travel the Continents provides shorter length, first-class deluxe trips that are value-priced. Innovative itineraries combine the best of land and cruise programming. Flexibility to choose pre- and/or post-tours are the option of the traveler. Credit cards are accepted for all payments. Continuing medical education programs are presented at a modest fee on the majority of the TravCon tours.

Conclusion
The Council on Member Services will make every attempt to continue to provide high-quality and competitive services through the preferred vendor programs. The Council welcomes any and all comments and suggestions regarding any of the member service activities.

Budget Request: $1,400

Respectfully submitted,
David Nierenberg, MD, Chair

■ REPORT OF THE OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Jack J. Beller, MD, Chair
Referred to: Reference Committee III
(A-2000)

Introduction
The Oklahoma Medical Political Action Committee is a voluntary, bi-partisan, unincorporated entity comprised of OSMA members, OSMA staff, and OSMA Alliance members interested in supporting political candidates. Primarily, OMPAC is an independent and autonomous organization managed by its own Board of Directors. The Board of Directors has authority over all policies and activities of the political action committee and serve without compensation. The OMPAC Board conducts the business of the committee and meets periodically to consider the contribution of OMPAC funds to candidates for public office who support OSMA's legislative agenda.

Review of Activities
OMPAC has conducted five solicitations for membership thus far for 2000. An OMPAC brochure containing the contributor's statement was mailed to each physician's office with their 2000 OSMA dues statement in the fall of 1999. As was the case in 1999, the separate solicitation was necessary due to strict Oklahoma Ethics Commission rules. In late October, the annual Legislative Report was mailed to all OSMA and OSMA Alliance members. This report contained a summary of all legislation tracked by the OSMA during the 1999 legislative session. Included in the report was an OMPAC solicitation card which could be removed and returned with a contribution. In January 2000, the OSMA Alliance OMPAC chair, Andrea Jones, mailed a solicitation letter to all Alliance members in the state. Also in January a letter was mailed to the homes of all physicians who had not joined OMPAC by that time. This letter pointed out the various battles that will be fought at the Capitol during this legislative session on behalf of physicians and their patients. AMPAC prepared and mailed, at no cost to OMPAC, a solicitation resembling an invoice on behalf of OMPAC to all eligible physicians in March.

Additional solicitation letters will be sent to OSMA delegates and past contributors within the next month, and OMPAC will have a manned booth at the Annual Meeting to encourage all physician and Alliance participants to join OMPAC.

OMPAC has a marketing budget of $7,000 from the American Medical Political Action Committee, and to date has been reimbursed for $2,230 of costs associated with soliciting members.

A vacancy on the OMPAC Board in District VI was created by the untimely death of Perry Lambird, MD. The Board voted at its February 29, 2000 meeting to fill this slot and chose Dr. Phil Self from Alva as the new Board member.

The OMPAC Board has voted to support the following legislators thus far in 2000 with the contributions listed below. These contributions are given in an ongoing effort to fulfill the wishes of the OMPAC board which voted to give the maximum amount possible to those legislators who voted with the OSMA on SB 1192, the laser surgery bill.

District 61	Representative Jack Begley	$250
District 23	Representative Betty Boyd	1,000
District 101	Representative Forrest Claunch	250
District 57	Representative James Covey	350
District 97	Representative Kevin Cox	500
District 28	Representative Mike Ervin	350
District 19	Representative Randall Erwin	250
District 35	Representative Larry Ferguson	350
District 18	Representative Lloyd Fields	350
District 72	Representative Darrell Gilbert	350
District 12	Representative Jerry Hefner	250
District 5	Representative Joe Hutchison	250
District 46	Representative Doug Miller	500
District 74	Representative Phil Ostrander	350
District 92	Representative Bob Plunk	250
District 59	Representative Clay Pope	350
District 66	Representative Russ Roach	500
District 49	Representative Fred Stanley	500
District 36	Representative Joe Sweeden	350
District 30	Representative Michael Tyler	350
District 17	Senator Brad Henry	400
District 2	Senator Stratton Taylor	500*
District 15	Senator Trish Weedn	350
Insurance Commissioner Carroll Fisher		1,000

**The OMPAC Board felt that since Senator Taylor is the Senate Pro Tem and was instrumental in helping with peer review legislation and OSMA's trauma bill that OMPAC should contribute to him at this time.*

Kathy Musson, OMPAC Director, attended an AMPAC meeting in Washington, DC in March. During this strategy meeting, staff members from state PACs had the opportunity to discuss a number of issues affecting PAC membership. Topics covered included AMPAC political contributions, membership goals and methods of solicitation, the role of the AMPAC Board of Directors, discussion of various AMA and AMPAC political education programs, and details of the AMPAC Grassroots Grant Program. OMPAC staff plans to submit a Grassroots Grant application later this year. The OMPAC Board continues to monitor any contribution requests to national campaigns and submits such requests to

AMPAC, which makes contributions only with OMPAC's approval.

OMPAC Financial/Membership Report
2000 1st Quarter
(As of April 4, 2000)

Financial:

1999 Carryover Balance	$ 43,177.25
Total Contributions	
Deposited in 2000	24,625.00
Subtotal	$ 67,802.25
Less Dues Paid to AMPAC	$ 7,500.00
Less Administrative Expenses	261.40
Less Contributions to	
Candidates in 2000	9,900.00
Subtotal	$17,661.40
Total Cash on Hand	$ 50,140.85

Membership:

Alliance Members	34
OSMA Staff Members	2
Physician Members	195
Total 2000 Membership as of 4/4/00	231

In addition to making sizeable contributions, OMPAC members participated as hosts and sponsors of fundraising events for many candidates. OMPAC members and staff worked with candidates to provide extra support for their campaign efforts in the organization of the fundraisers, raising individual contributions from OSMA members, and obtaining permission from OSMA members to be listed as hosts and sponsors of these events.

Conclusion
OMPAC will hold its annual membership meeting during the OSMA Annual Meeting on Saturday, May 6 at 1:30 p.m. The Board will hold a joint luncheon with the Council on Governmental Activities at noon on Saturday, and the luncheon will be open to all OSMA and Alliance members. Strong leadership and physician involvement is critical to OMPAC's future success in enhancing OSMA's legislative efforts.

Attached is a listing of the current year's OMPAC members (see Attachment 1).

Budget Request: $11,800

Respectfully submitted,
Jack J. Beller, MD, Chair

ATTACHMENT 1

2000 OMPAC Members
(as of April 10, 2000)
Yoo Chul Ahn, MD, Elk City
D. Randel Allen, MD, Oklahoma City
M. Dewayne Andrews, MD, Oklahoma City
John C. Andrus, MD, Oklahoma City
Michel A. Arcand, MD, Norman
Mrs. Cheryl Baker, Edmond
Mrs. Connie Baker, Oklahoma City
R. Stanley Baker, MD, Oklahoma City
Ray M. Balyeat, MD, Tulsa
Ronald D. Barber, MD, Ardmore
Penni Barrett, MD, Tulsa
Ann E. Bartoloni, MD, Tulsa
Jaafar M. Bazih, MD, Tulsa
Zachary T. Bechtol, MD, Jay
Donald E. Becker, MD, Blackwell
Mrs. Joyce Becker, Blackwell
David William Behm, DO, Lawton
Jack J. Beller, MD, Norman
Mrs. Ruth Beller, Norman
William G. Bernhardt, MD, Midwest City
Mrs. Colleen Bicket, Edmond
Paul Charles Bicket, MD, Edmond
George Blake, MD, Tulsa
Jerry B. Blankenship, MD, Enid
J. Gebhard Blum, MD, Tulsa
Richard J. Boatsman, MD, Lawton
Mrs. Cecelia Bohan, Oklahoma City
John R. Bozalis, MD, Oklahoma City
Edward N. Brandt, Jr., MD, Oklahoma City
Mrs. Sandy Breipohl, Tulsa
Mrs. Jennifer Brewer, Duncan
Robert C. Brown, MD, Oklahoma City
Chester L. Bynum, MD, Norman
George B. Caldwell, MD, Tulsa
Mrs. K Caldwell, Tulsa
Tim S. Caldwell, MD, Tulsa
Scott W. Calhoon, MD, Oklahoma City
Charles L. Cannon, MD, Enid
Lawrence M. Cibula, MD, Muskogee
James R. Claflin, MD, Edmond
Kenneth P. Coffey, MD, Edmond
D. Glen Coles, MD, Shawnee
James C. Connors, MD, Tulsa
Betty L. Conrad, MD, Tulsa
Donald L. Cooper, MD, Stillwater
Bert N. Corley, MD, Sallisaw
E.P. Couch, MD, Muskogee
Mrs. Mary Ann Couch, Muskogee
Steven A. Crawford, MD, Oklahoma City
Mrs. Judy Critchfield, Muskogee
Mickey Crittenden, MD, Edmond
James Steven Day, MD, Tulsa
Scott A. Dempewolf, MD, Ardmore
Gary T. Denslow, MD, Tulsa
Sara Reed DePersio, MD, Edmond
John W. DeVore, MD, Oklahoma City
Glen Diacon, Jr., MD, Ada
Billy D. Dotter, MD, Okeene
Roy J. Doty, MD, Ada
James L. Dunagin, Jr., MD, McAlester
Jodie L. Edge, MD, Norman
John W. Ellis, MD, Edmond
Robert S. Ellis, MD, Oklahoma City
Mrs. Jonna Emmons, Edmond
Steven W. Emmons, MD, Edmond
Charles F. Engles, Jr., MD, Oklahoma City
Lee H. Falk, MD, Lawton
John K. Falsarella, MD, Ada
William M. Featherston, MD, Elk City
Warren V. Filley, MD, Edmond
Mark W. Fogle, MD, Lawton
Lynn Edward Frame, MD, Tulsa
Kurt Frantz, MD, Enid
Mrs. Josephine Freede, Oklahoma City
Eric E. Frische, MD, Lawton
Andrew F. Frost, MD, Norman
Bennett E. Fuller, MD, Edmond
Steven E. Gaede, MD, Tulsa
E. Bradley Garber, Jr., MD, Tulsa
Donald H. Garrett, MD, Lawton
Charles Gebetsberger, MD, Sapulpa
William A. Geffen, MD, Tulsa
Campbell M. Gillespie III, MD, Norman
Charles Girard, MD, Tulsa
Mark B. Goering, MD, Enid
Marc A. Goldberg, MD, Tulsa
Linda Goldenstern, MD, Tulsa
R. Nathan Grantham, MD, Lawton
Mrs. Edie Gregory, Muskogee
Tim L. Grode, MD, Edmond
I. Peyton Haralson, Jr., MD, Muskogee
Susan M. Harmon, MD, Edmond
David L. Harper, MD, Tulsa
William P. Harris, MD, Norman
William S. Harrison, MD, Chickasha
Mrs. Mary Ann Harroz, Oklahoma City
Barbara A. Hastings, MD, Tulsa
John W. Hatchett, MD, Bartlesville
William D. Hawk, MD, Oklahoma City
Jeanne O. Hayes, MD, Tulsa
Mark Alan Hayes, MD, Tulsa
James L. Henderson, MD, Muskogee
Philip James Hess, MD, Tulsa
Joe S. Hester, MD, Muskogee
Melvin V. Holman, MD, Norman
Carl T. Hook, MD, Norman
Mrs. Sandra Hook, Norman
Ellen E. Hope, MD, Oklahoma City
John R. Houck, Jr., MD, Edmond
Charles N. Howard, Jr., MD, Pauls Valley
John M. Huser, Jr., MD, Weatherford
Mrs. Barbara Jett, Oklahoma City
Mason Peck Jett, MD, Oklahoma City
Andrew C. John, MD, Oklahoma City
Gary A. Johnson, MD, Oklahoma City
Linda D. Johnson, MD, Lawton
William P. Jolly, MD, Lawton
Mrs. Andrea Jones, Oklahoma City
Jeffrey C. Jones, MD, Duncan
Ashok Kache, MD, Tulsa
Paul A. Kammerlocher, MD, Tuttle
Daniel F. Keller, MD, Oklahoma City

William F. Kern III, MD, Norman
Kristina M. Kline, MD, Tulsa
John C. Kramer, MD, Tulsa
Kenyon K. Kugler, MD, Tulsa
H. T. Kurkjian, MD, Oklahoma City
Kim L. Kurvink, MD, McAlester
David Louis Kyger, MD, Muskogee
Robert M. Lambert, MD, Norman
Gary Lynn Larson, MD, Oklahoma City
Lora J. Larson, MD, Tulsa
Jay E. Leemaster, MD, Norman
Mrs. Linda Leemaster, Norman
Alan Garth Lewis, MD, Tulsa
Timothy A. Lind, MD, Tulsa
George D. Lyons, MD, Tulsa
David B. Mallory, MD, Oklahoma City
Bradley J. Margo, Oklahoma City
G. Conrad Markert, MD, Stroud
John S. Marouk, DO, Tulsa
Mrs. Karen Mask, Edmond
Billy J. Matter, MD, Edmond
David L. McCarty, MD, Edmond
Michael G. McCauley, MD, Ardmore
William G. McCreight, Jr., MD, Oklahoma City
Kautilya A. Mehta, MD, Oklahoma City
Joe Paul Merritt, MD, Oklahoma City
Jack E. Metcalf, MD, Edmond
Frank R. Michener, MD, Lawton
Floyd F. Miller, MD, Tulsa
J. Steve Miller, MD, Tulsa
Marc S. Milsten, MD, Tulsa
Mrs. Jan Milton, Chickasha
Jack J. Mocnik, Jr., MD, Tulsa
Edward R. Munnell, MD, Oklahoma City
Mrs. Kathy Musson, Oklahoma City
John W. Nelson, MD, Oklahoma City
Lila V. Nevrekar, MD, Shawnee
Brent C. Nossaman, DO, Tulsa
Bruce E. O'Brien, MD, McAlester
Mrs. Keith Oehlert, Oklahoma City
William H. Oehlert, MD, Oklahoma City
Charles W. Olson, Jr., MD, Drumright
Robert W. Orbelo, MD, Norman
J. Mark Osborn, MD, Miami
Gary Lee Paddack, MD, Ada
Mrs. Susan Paddack, Ada
Mukesh T. Parekh, MD, Oklahoma City
Kenneth D. Parrott, MD, Okeene
W. F. Phelps, MD, Tulsa
Robert H. Phillips, MD, Stillwater
William G. Phillips, MD, Shawnee
George M. Pikler, MD, Tulsa
Pablo A. Pinzon, MD, Oklahoma City
George W. Prothro, MD, Tulsa
Jeffrey L. Reed, MD, Oklahoma City
David Linn Reinecke, MD, Cushing
Don F. Rhinehart, MD, Oklahoma City
Stephen B. Rhodes, MD, Oklahoma City
Mark A. Robertson, MD, Bartlesville
R. Clio Robertson, MD, Tulsa
Mrs. Mary Robideaux, Edmond
John A. Robinson, MD, Shawnee
John R. Rogers, MD, Edmond
Arthur W. Rousseau, MD, Oklahoma City
David Russell, MD, Enid
John Carl Sacra, MD, Tulsa
Muhammad Salim, MD, Norman
Mrs. Leslie Samara, Oklahoma City
Ronad Schatzman, MD, McAlester
William M. Schnitz, MD, Oklahoma City
Lee E. Schoeffler, MD, Broken Arrow
Glenn W. Schoenhals, MD, Oklahoma City
David M. Selby, MD, Enid
Philip Mark Self, MD, Alva
William J. Settle, MD, Guymon
Ernest G. Shadid, MD, Norman
Jeffrey T. Shaver, MD, Edmond
Teresa M. Shavney, MD, Oklahoma City
Howard A. Shaw, MD, Tulsa
William W. Sheehan, MD, Tulsa
Roger E. Sheldon, MD, Oklahoma City
Thurman Shuller, MD, McAlester
Richard C. Slagle, MD, Tulsa
Tim K. Smalley, MD, Stillwater
Brad V. Smith, MD, Broken Arrow
Jeffrey J. Smith, MD, Edmond
Mrs. Karen Smith, Norman
H. Thomas Snyder, MD, Enid
Joseph W. Stafford, MD, Enid
Rex E. Stockard, MD, Lawton
Bruce C. Stoesser, MD, Tulsa
Martin L. Stokes, MD, Ada
Mrs. Jan Storms, Chickasha
Donald R. Stout, MD, Tulsa
Gary F. Strebel, MD, Oklahoma City
Mrs. Sherry Strebel, Oklahoma City
Mrs. Mary Ellen Tallerico, Edmond
Ralf E. Taupmann, MD, Edmond
Edward L. Taylor IV, MD, Tulsa
James R. Taylor, MD, Bartlesville
J. T. Terry, MD, Ponca City
Harold Dean Thiessen, MD, Edmond
Jane M. Thomason, MD, Ponca City
Mrs. Sherry Tipton, Edmond
Mrs. Kimberly Tkach, Edmond
Thomas K. Tkach, MD, Edmond
S. Fulton Tompkins, MD, Oklahoma City
Richard Trautman, MD, Oklahoma City
Joel K. Troop, MD, Ardmore
John B. Vosburgh, MD, Tulsa
J. Walia, MD, Oklahoma City
John Emmett Ward, MD, Oklahoma City
Ann A. Warn, MD, Lawton
Charles C. Weddle, MD, Edmond
Mrs. Julie Weedn, Duncan
Robert J. Weedn, MD, Duncan
Roger E. Wehrs, MD, Tulsa
James R. Wendelken, MD, Oklahoma City
Mrs. Nora White, Tulsa
Robert S. White, MD, Tulsa
Boyd O. Whitlock, MD, Tulsa
Mrs. Myrna Whitlock, Tulsa
Mrs. Alice Whittington, Oklahoma City
Kenneth Whittington, MD, Bethany
Gregory P. Williams, MD, Tulsa
Chauncey B. Witcraft III, MD, Miami
Robert C. Wright, MD, Stillwater
Stephen Yeich, MD, Edmond
James C. Ziegler, MD, Lawton

REPORT OF THE PHYSICIAN RECOVERY COMMITTEE

CONSENT CALENDAR
Subject: Annual Report
Presented by: James Gormley, MD, Chair
Referred to: Reference Committee III (A-2000)

Introduction
The OSMA Physician Recovery Program, which started in 1983, continues to maintain an effective statewide non-coercive advocacy program for identifying, contacting and offering rehabilitative help, ongoing monitoring for licensure and other purposes for health care professionals (MD, DO, DDS, DVM, PA) suffering from alcoholism, substance dependence, and other addictive disorders. The PRP also serves as a confidential, informational support and referral source for physicians, other health care professionals and spouses for behavioral health issues as well as physical impairments.

Review of Activities
The Physicians Recovery Committee met on Wednesday, September 15, 1999. Billy Stout, MD, chaired the meeting for Dr. James Gormley.

Discussion Items

- The Committee reviewed the revenue received from PLICO, the Osteopathic Association, and the Dental Association. Comments were made that the Physicians Assistants Association will be sending in approximately $6,000 per year. Recommendations were made to have Harold Thiessen, MD, Director of the Physicians Recovery Program (PRP), contact the Osteopathic Association and request an increase in their support from $12,000 to $24,000.

- The Committee approved the salary increases for the Director and Associate Directors. (See Physicians Recovery Program Budget.)

- The Committee reviewed the Colorado Personalized Education for Physicians Program (CPEP). CPEP provides a personalized and systematic process to

address physicians' educational needs in scientific knowledge, technical skills, and interpersonal skills as they relate to medical practice. This program is currently under the OSMA Liaison Committee for Medical Schools. Recommendations were made to have the CPEP program included with the Physicians Recovery Program (PRP) and loans to be made for the CPEP program to fall under the guidelines of the PRP. A steering committee for CPEP has been formed and will be working with this committee to develop guidelines.

- The Committee reviewed the PRP guidelines approved by the Board of Trustees in 1994 and approved the attached revisions. (See Attachment I).

- James Gormley, MD, Chairman, attended the Education & Research Foundation's Board Meeting on March 6, 2000, and discussed the future plans and growth opportunities for the Physicians Recovery Program. Dr. Gormley will be making a report to the OSMA Board of Trustees at their May 4th meeting.

Recommendations

- Approval of the recommended changes to the Physicians Recovery Program Guidelines.
- Approval of the CPEP program to fall under the guidelines of the PRP.

Conclusions

The Committee will continue to work with the Physicians Recovery Program Director and members of the Association as an outreach to support and monitor medical professionals throughout Oklahoma who are experiencing difficulty with substance abuse.

Budget request: $145,200

Respectfully submitted,
James B. Gormley, MD, Chair

ATTACHMENT I

Revisions to the Physician Recovery Program Guidelines

Purpose

The stated purpose of the Physician Recovery Program (PRP) is to evaluate impaired physicians and to facilitate the return to public service those physicians who are in recovery from a drug or alcohol addiction, or any other impairing process.

Eligibility Requirements

For eligibility purposes, the term physician shall refer to a medical doctor, a doctor of osteopathy, a doctor of dental sciences, or a doctor of veterinary medicine. Also eligible shall be students of medical schools, students of schools of osteopathy, dental students, or students of schools of veterinary medicine. Spouses of any aforementioned individual shall also be eligible for the PRP.

In order for an individual to enter the PRP, the individual must have a documented addiction problem or be impaired in any manner and said individual willingly commits himself or herself to the PRP.

Administration of the PRP

A Director and Associate Director(s), if necessary, shall be retained by the Oklahoma State Medical Association (OSMA) to administer the PRP. Selection of said directors of the PRP shall be made by the Board of Trustees of the OSMA. Approval of and compensation for the directors shall be established by the Board of Trustees of the OSMA and approved by the House of Delegates of the OSMA.

An Advisory Committee shall be nominated by the President of the OSMA and approved by the Board of Trustees. The committee shall consist of no less than seven (7) but no more than fifteen (15) individuals. From time to time, the Committee and or Director shall retain consultants to provide necessary input as conditions warrant. Compensation for such consultation shall be approved by the Board of Trustees of the OSMA.

The purpose of the Advisory Committee shall be to assist the Director or Associate Director(s) in the policy setting process as well as in implementation of policies necessary for the successful operation of the PRP.

~~The Board of Trustees of the OSMA on behalf of~~ The Director and or Associate Director shall retain such secretarial support as deemed necessary to carry out the functions of the PRP.

Admission Into the PRP

Admission is open to any and all meeting the eligibility requirements as stated above. The individual must show a willingness and a desire to recover. The individual must voluntarily enter the PRP and commit himself or herself to treatment in one of the authorized providers to be defined in subsequent paragraphs.

Intervention Process of the PRP

Upon a request for assistance regarding a suspected impaired individual, the PRP shall proceed into a discovery process which will elicit input from sources which may have knowledge of the individual in question. Such sources shall include, but shall not be restricted to: medical colleagues, partners, hospital staff members, medical societies (county or others), medical licensing boards, or concerned others (family members, friends, patients).

Upon completion of the discovery process, the PRP shall then proceed into the investigative process to validate the information brought forth during discovery.

Based upon the findings of the investigation, the PRP will make the decision to, or not to, proceed with an intervention. If an intervention is deemed in order, then appropriate meetings will be conducted with the impaired individual and concerned parties to make appropriate referral to authorized providers.

Authorized Providers

COPAC - Jackson Recovery Center, Jackson, Mississippi
Talbott - Marsh Recovery Center, Atlanta, Georgia
Rush Behavioral Health Center, Downers Grove, Illinois
William Farley, Williamburg, Virginia
Palmetto Addiction Center, Rayville, Louisiana
Colorado Personalized Education for Physicians Assessment Program (CPEP)

Financial Assistance

Financial assistance will be available only to eligible *OSMA member* ~~MD~~ physicians, ~~MD~~ physician spouses, ~~MD~~ medical students and ~~MD~~ medical student spouses and dependent children who have entered the recovery *or rehabilitation* process. This assistance will be made through the OSMA Foundation and upon the individual returning to pubic life, this assistance will be reimbursed to the OSMA Foundation by the individual.

The need for financial assistance shall be validated by the Director and Associate Director*(s)* with input of the Advisory Committee if need be. The request for assistance shall then in turn be forwarded to the Foundation of the OSMA for disbursement of funds in accordance with the policy and procedures of the Foundation.

Reimbursement of the financial assistance shall occur under specific terms of a written agreement between the individual and the OSMA. The agreement shall take the form of a secured ~~demand~~ *promissory* note, with a stated rate of interest (to be determined by the then current local prime interest rate), and secured by any assets held

by the individual or the individual's corporation at the time the agreement is entered.

The written agreement referred in the preceding paragraph shall be consummated no later than such times as when the individual enters into his or her After Care contract with the authorized provider and the PRP.

If the individual for any reason falters on his or her responsibilities as so stated in the agreement, then OSMA reserves the right to initiate collection proceedings against the individual in any manner which is in the best interest of the OSMA.

Reporting of the Program

The Director or Associate Director*(s)* shall make reports to the Board of Trustees of the OSMA at each quarterly regularly scheduled meeting of the Board. Such reports shall include information regarding the number of individuals currently in the PRP, the number of individuals currently in recovery, and a financial statement which details the financial assistance portion of the PRP. Said reports shall contain no identifiable information traceable to any individual currently in the PRP or in recovery.

Presented to the President of the OSMA
11-14-99

■ REPORT OF THE PHYSICIAN RECOVERY PROGRAM

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Harold Thiessen, MD, Director
Referred to: Reference Committee III (A-2000)

Review of Activities

Since 1983, the Oklahoma State Medical Association has provided services to physicians with alcohol and chemical dependence. The Physician Recovery Program (PRP) is an outreach program designed to support and monitor medical professionals throughout Oklahoma who are experiencing difficulty with substance abuse. The OSMA Physician Recovery Program continues to be among the leaders nationally in identifying, assisting in treatment, and returning to practice physicians who have suffered from substance abuse/dependency.

Because of the commitment to provide resources to physicians in need, PRP employs a medical director and two part-time associate directors, all physicians, to administer the program.

An important part of the program continues to be providing documentation of the treatment and recovery status of our physicians (and other health care professionals) for licensing boards, drug registration agencies, insurance carriers, hospitals, and health maintenance organizations.

The PRP program has helped approximately six hundred-six (606) licensed professionals (MD, DO, medical students, DDS, Alliance, and physician assistants) since 1983. Eighty-five (85) percent recovery rate with ninety-five (95) percent of the participants returning to practice.

Program Update

Actively involved in PRP program: 150
75 - OKC area
70 - Tulsa area
5 - Rural area

Monitored with drug screens: 43
(out of the 150 actively involved)
26 - OKC area
15 - MDs
7 - DOs
3 - dentist
1 - physician assistant
17 - Tulsa area

Attending weekly medical support groups:
35 - OKC area
30 - Tulsa area
6 - rural area

Review of activities,
April 1999-April 2000:
56 contacts
37 MDs
8 dentists
7 DOs
1 veterinarian
2 PhDs
1 medical student

28 assessments completed on the 56 contacts
15 MDs
6 dentists
6 DOs
1 medical student

23 treatments from the 28 assessments (7 re-treatment)
14 MDs
5 dentists
3 DOs
1 medical student

As a note: 1 spouse, 1 physician assistant, 1 respiratory therapist entered treatment.

Respectfully submitted,
Harold Thiessen, MD, Director

■ REPORT OF THE COUNCIL ON STATE LEGISLATION AND REGULATION

FILED FOR INFORMATION
Subject: Annual Report
Presented by: Edward N. Brandt, Jr., MD, Chair
Referred to: Reference Committee III (A-2000)

Introduction

The Second Session of the Forty-Seventh Legislature convened on Monday, February 7, 2000. There were 1,050 bills and resolutions this year, and there were 457 carry-over measures from last session on the House side alone. On the Senate side, 975 measures were introduced with 535 carry-overs from last year. At the beginning of the session, the OSMA was tracking over 400 bills related to healthcare, insurance, and other areas of interest to medical doctors and their patients. Several pieces of this legislation were initiated by the OSMA.

The OSMA added the assistance of Dan Draper to their lobby effort to aid Lynne White, OSMA Chief Lobbyist.

The Council on State Legislation has met bi-weekly since January 4, 2000 and will continue to meet as needed until Sine Die (the last day of Session), on May 26, 2000.

Review of Activities

1999 Legislative Session Overview

The first session of the Forty-Seventh Legislature convened Monday, February 1, 1999. The House and the Senate combined filed 1756 pieces of legislation. At the beginning of the session, the OSMA was tracking over 200 bills related to health care, insurance, and other areas of interest to medical doctors and their patients; several of these bills were initiated by the OSMA.

Each year the state legislative session brings new challenges, new opportunities, and some disappointments for medical doctors and their patients. The 1999 Legislative Session was a good one for the practice of medicine and for patients' rights. The OSMA found itself in the forefront of lobbying efforts on behalf of patients' rights, torts, insurance, and scope of practice issues as well as working with tobacco-free advocates to capture for public health purposes the Tobacco Master Settlement Agreement proceeds, over $2 billion allocated for the state of Oklahoma over the next 25 years.

A summary of all of the legislation which was OSMA initiated, supported, opposed, or strongly opposed during the session of 1999 was provided in the annual

OSMA *Legislative Report*. The report was mailed to all OSMA members and Alliance members in the fall of 1999. Extra copies are available at OSMA Headquarters.

The OSMA Council on State Legislation and Regulation submitted the following goals and they were approved by the Board of Trustees for the 2000 legislative session.

OSMA 1999-2000 Legislative Goals

Goal 1: General Health Issues

Promote legislation that will enhance the health and well-being of the public.

Objective: Encourage the prevention of health problems, and promote healthy lifestyles, early intervention and appropriate treatment.

For Example:

1. Support public policy and legislation curbing tobacco use (#1 priority).
 A. Legislation for a vote of the people to establish a trust fund for tobacco settlement monies.
 B. Allow local communities to pass their own regulations on tobacco use and sales tougher than current state law.
 C. Promote legislation providing for penalties for owners of any company selling tobacco products to minors.
 D. Promote legislation to require strict enforcement of penalties.
2. Support legislation aimed at the control or prevention of violence, especially family violence in Oklahoma.
3. Seek adequate funding for the Poison Control Center.
4. Seek legislation to mandate insurance coverage of contraception.
5. Support public policy that would improve access to medical and public health services for all Oklahomans.
6. Continue active support of a strong medical education system to benefit future Oklahomans.
7. Oppose unreasonable restrictions on Ambulatory Surgery Centers (ASCs).
8. Explore legislation regarding psychological counseling for students who bring guns to school.

Goal 2: Insurance and Regulation Issues

Promote legislation that will protect and enhance patient access to appropriate quality care provided by medical and osteopathic physicians without the negative interference of insurance companies and regulatory entities.

Objective: Prevent any delay or denial of medically necessary patient diagnostic and treatment options while protecting the autonomy of the physician in medical decision making.

For Example:

1. Advocate legislation that will implement effective physician- and patient-friendly approaches to the implementation of managed care.
2. Seek methods for appropriately regulating the quality of care delivered by Managed Care Organizations (MCOs).

 Note: 1 and 2 to be accomplished by modifications of the Texas negotiating bill.
3. Promote legislative and regulatory protection for fair, reasonable, and appropriate medical fees.
4. Monitor the implementation of Sooner Care and address problems arising therefrom.

Goal 3: Scope of Practice

To provide the maximum protection of patients' health by assuring the best quality of care.

Objective: Preserve and protect the autonomy of all medical and osteopathic physicians in providing the highest quality of patient care and protect the public from health care providers who are less qualified.

For Example:

1. Resist any attempt by optometrists to increase their scope of practice and resist any attempts for prescribing privileges or any other increase in the scope of practice by pharmacists, optometrists, nurses, chiropractors, and others.

Goal 4: Tort Reform

Promote legislation that will provide fairness and efficiency at all levels (District, Appellate and Supreme Court) of the civil justice system, especially in the professional and product liability arena.

Objectives: Preclude attempts to put the defendant physician(s) at a direct or indirect disadvantage in the medical malpractice lawsuit. To obviate professional liability tort laws that coerce the physician into pretrial settlement.

Goal 5: Workers Compensation

Review and monitor workers compensation legislation to determine the impact on physicians who render medical services in the workers compensation environment.

Objective: Prevent any change of the workers compensation laws that adversely affect the way medical or osteopathic physicians deliver care to an injured worker and support such changes that improve such care.

Status of 2000 Legislation

Thursday, March 30, was the deadline for measures to be reported from the committee in the opposite House of introduction. Measures that did not receive a hearing in committee or were defeated are dead for the remainder of this legislative session. Thursday, April 20 is the deadline for bills to be reported from the Floor of the opposite house.

Title stricken – Constitutionally, every measure must have a title that describes the general subject to be addressed. Examples are: "An Act Relating to Public Health and Safety" or "An Act Relating to Professions and Occupations." Since all enacted bills must have a title, it is a common action in the legislative process to "strike" the title of the bill by amendment to ensure that the bill will go to a conference committee for further work. This strategy gives legislators a final opportunity to amend a bill in conference before restoring the title to the bill for Fourth Reading.

Tobacco

Tobacco Prevention and Cessation Programs

The OSMA joins the Tobacco Free Oklahoma Coalition in urging the legislature to appropriate $15 million in fiscal year 2001 to the State Department of Health to support comprehensive community based programs for tobacco prevention and cessation. Our goal is to achieve a funding level of $30 million annually beginning in 2002.

Tobacco Settlement Funds

- The OSMA strongly supports investing tobacco settlement revenues in a trust fund. Currently there are several proposals by the House and Senate leadership to invest these funds. All of these bills, if passed by both Houses of the Legislature, will go to the Joint Conference

Committee on Appropriations (GCCA), at which time the various proposals will be fully discussed.

- The OSMA favors the creation of a constitutional trust fund. Should a measure be passed by both Houses of the Legislature, it will create the Tobacco Settlement Endowment Trust Fund. The measure will be placed on the ballot at a statewide election and, if approved by voters, will create the endowment trust fund. The provisions of the constitutional amendment cannot be changed except by another vote of the people. Should this measure be approved, the payments to the trust fund would, most likely, not begin until fiscal year 2002 due to the certification of revenue process.

HB 2022 and SB 1404 by Speaker of the House Loyd Benson and Senate President Pro Tempore Stratton Taylor create statutory trust funds. The OSMA prefers the constitutional rather than the statutory approach. The OSMA is supportive of all efforts to create a trust fund. *Titles stricken. Introduced in opposite Houses, both on General Order.*

Legislation Initiated by Oklahoma State Medical Association (OSMA)

HB 1954, Extends Medicaid Coverage for Twelve Months, by Billy Mitchell of the House and Angela Monson of the Senate, directs the Oklahoma Health Care Authority to promulgate rules by December 1, 2000, that will extend coverage for twelve months for guaranteed health care services to eligible Medicaid recipients. Fiscal staff projects the cost to be $2.5 million. *Title stricken. General Order in the Senate.*

HB 2072, Prudent Layperson Standard, by Fred Morgan of the House and Ben Brown of the Senate, amends OSMA's 1997 "Fairness In Managed Care Act," by adding, "decisions by managed care plans to authorize or deny coverage for an emergency service shall be based on the patient's presenting symptoms arising from any injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in (1) serious jeopardy to the patient's health; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part." Further the legislation provides that "plans shall not deny an otherwise covered emergency service based solely upon lack of notification to the plan; and plans shall compensate a provider for patient screening, evaluating, and examining services that are reasonably calculated to assist the provider in determining whether the patient's condition requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the plan contract." The OSMA is working with the authors to amend the bill to include similar provisions for preferred provider organizations and other insurance plans. *General Order in the Senate.*

HB 2593, Unused Prescription Drugs – Medically Indigent, by John Bryant of the House and Bernest Cain of the Senate, directs the State Board of Health and the State Board of Pharmacy to jointly develop a program whereby unused, non-narcotic prescription drugs may be transferred from nursing homes to repositories established for the purpose of distributing the medication to Oklahoma residents who are medically indigent. *General Order in the Senate.*

Status of Legislation Strongly Supported by OSMA

SB 1206, The Managed Care Reform and Accountability Act, is supported by the OSMA. This legislation, if enacted, would allow patients to sue managed care entities for punitive damages. The Senate author, Senator Brad Henry, and the principle House author, Representative Opio Toure, and Representative Bill Settle also worked closely with the OSMA to assure that all our concerns are addressed.

Information about the proposed legislation is as follows:

- The proposed legislation will require a managed care entity (MCE) to exercise ordinary care when making medical decisions in conflict with the treating physician's medical decision.
- Under the proposed legislation, a patient may sue an MCE for negligence (failure to exercise ordinary care) without suing the treating physician. *(Under current law a patient must sue the treating physician for negligence in order to sue the MCE for negligence.)*
- MCEs can only be liable for health care treatment decisions that deny or delay needed care—not for decisions denying care not covered by the patient's insurance plan.
- MCEs will not be able to seek indemnity from the physician if the MCE is found liable. Even contract provisions giving MCEs a right to indemnity will be void and unenforceable.
- MCEs will not be able to cancel or fail to renew a provider contract with a physician because the physician advocated for a patient.
- The proposed legislation, if enacted, will require that a patient go through both internal and a state external review process before filing a lawsuit.

As of 4/11/00, SB 1206 passed the House of Representatives and will go back to the Senate for acceptance or rejection of House amendments.

HB 1872, Medical Micropigmentation, by Al Lindley of the House and Trish Weedn of the Senate.

This legislation addresses actions taken in the summer by the Board of Medical Licensure and Supervision and the Board of Dentists. Physicians and dentists supervising nurses or trained assistants who perform this procedure are in violation of Oklahoma's prohibition on tattooing. Under the tattooing statute only physicians in certain categories are allowed to perform any procedure considered to be tattooing. HB 1872 defines medical micropigmentation as a medical procedure. Medical doctors, osteopathic physicians, and dentists may perform the procedure and supervise nurses and trained assistants within their scope of practice and training. Assistants shall be prohibited from administering any medications associated with the procedure and shall be required to complete educational course work within twelve months of the enactment of this legislation. *General Order in the Senate.*

HB 1885, Assault on Emergency Medical Care Providers, by Mike Wilt of the House and James Dunlap of the Senate, amends current law by changing assault, battery, or assault and battery upon an emergency medical care provider who is performing medical care duties, upon conviction, from a misdemeanor to a felony punishable by imprisonment for up to one year, or by a fine of up to $1000 or both. The OSMA is working with the bill's authors to expand the provisions of the bill to include all health care providers performing medical care duties. *Title stricken. General Order in the Senate.*

HB 1918, Teleradiology Standards, by Betty Boyd of the House and Ben

Robinson of the Senate, is legislation initiated by the Oklahoma State Radiological Society and strongly supported by the Oklahoma State Medical Association and the Oklahoma Telemedicine Advisory Council. The bill, if enacted, requires the State Board of Health to promulgate rules for teleradiology standards based upon the American College of Radiology Standard for Teleradiology. ***Governor signed.***

HB 2559, Explanation of Benefits, by Mike Ervin of the House and Jerry Smith of the Senate, amends the Health Care Freedom of Choice Act by requiring that upon a submission of a claim by a provider to an insurer on a uniform health care claim form, adopted by the Insurance Commissioner, the insurer shall provide a timely explanation of benefits to the provider (practitioner, hospital, home care agency, or ambulatory surgery center) regardless of the network participation status of such person or entity. *General Order in the Senate.*

Bills Strongly Opposed by OSMA Die in Committees

HB 2664, State Board of Homeopathic Physicians and Surgeons, by Ron Kirby of the House, provides for the creation of a new state board that would determine the licensure requirements and scope of practice of homeopathic practitioners.

The members of the Public Health Committee expressed concerns about the construction of this legislation because it appeared to give broad powers to this board to determine scope of practice. *The bill died for lack of a second. Report Progress in House Committee on Public Health.*

SB 1005, Insurance – High Risk Pool, by Gene Stipe of the Senate and M.C. Leist of the House, which relates to the High Risk Pool Act and removes the Oklahoma State and Education Employees Group Insurance Plan as an insurer. This provision was defeated in the 1999 session and continues to be opposed by the OSMA and the Oklahoma Hospital Association. *Report Progress from the Senate Committee on Human Resources.*

SB 1083, Workplace Drug and Alcohol Testing, by Paul Muegge of the Senate, amends current law by prohibiting the use of hair as a sample for drug and alcohol testing. *Report Progress in Senate Committee on Judiciary.*

SB 1590, Naturopathic Medicine Licensure Act, by Angela Monson of the Senate, provides for licensure of naturopathic practitioners by the State Board of Medical Licensure and Supervision, determines scope of practice and educational requirements. The bill creates a Naturopathic Physicians Advisory Committee to advise the Board of Medical Licensure and Supervision. *Report Progress in Senate Committee on Business and Labor.*

Other Legislation of Interest

Telemedicine

HB 1947, Oklahoma Center for Telemedicine, by Mike Ervin of the House and Ben Robinson of the Senate, is the vehicle initiated by the State Telemedicine Advisory Council. The bill creates the Oklahoma Center for Telemedicine. The Telemedicine Advisory Council would serve as an advisory body to the State Board of Health, the Commissioner of Health and the Oklahoma Center for Telemedicine. The bill directs the State Board of Health to establish the Oklahoma Center for Telemedicine as a separate unit of the State Department of Health, which will report directly to the Board and the Commissioner. The bill also directs the Center to establish and maintain a telehealth website and a clearinghouse for grant information. *Title stricken. General Order in the Senate.*

SB 1252, by Ben Robinson of the Senate and Mike Ervin of the House, provides each not-for-profit hospital, upon written request, receive, free of charge, one telecommunications line or wireless connection sufficient for providing such telemedicine services as the hospital is equipped to provide. The telecommunications carrier shall be entitled to reimbursement from the Oklahoma Universal Service Fund for providing the line or connection. In no case, however, shall reimbursement from the fund be made for an internet subscriber fee or charges incurred as a result of services accessed via the internet. *Title stricken. House amendments pending in the Senate.*

Workers Compensation

SB 1606, by Scott Pruitt of the Senate and Fred Morgan of the House, provides for an administrative worker's compensation system to replace the current judicial system. There are several bills in this area. *Title stricken. Introduced in the House, House amendments read.*

Workers compensation bills that survive deadlines will, most likely, go to a joint conference committee. The OSMA is monitoring this legislation for the inclusion of provisions related to medical fee schedules and medical cost containment.

Insurance

HB 2576, Immunizations, by Kevin Cox of the House and Maxine Horner of the Senate, provides an exclusion for coverage of childhood immunization insurance coverage for short-term health insurance policies issued on a non-renewable basis with a duration of six months. *General Order in the Senate.*

Claims Legislation: HB 2582, by Bobby Frame of the House and Frank Shurden of the Senate and **SB 1511**, by Lewis Long of the Senate and Randall Erwin of the House, are bills dealing with the "clean claims" and "prompt pay" provisions under the Insurance Code and the Public Health Code. The OSMA initiated SB 1511 to address the inconsistency and timelines for payment of claims in the codes. *HB 2582 – Title stricken. General Order in the Senate. SB 1511 – Title stricken. Died in House Committee on Insurance.*

HB 2647, Insurance Plan Internal Review, by Fred Morgan of the House and James Dunlap of the Senate, require health insurance plans to develop an internal review process with timelines and procedures for determination in emergency situations. Introduced in the Senate. *Died in Committee on Judiciary.*

SB 1588, Primary Care Provider, by Angela Monson of the Senate, requires an enrollee in a managed care plan to initially seek services from a primary care provider as defined by the managed care plan. *General Order in the House.*

Medicaid

Supplemental Funding – Oklahoma Health Care Authority

The Legislature passed a $9.3 million supplemental funding bill for the Oklahoma Health Care Authority (OHCA). The supplemental appropriation addresses a $5.1 million shortfall that resulted from a growth in Medicaid enrollment beyond what was anticipated in May 1999. Funding also included $1.3 million for the medically needy program, $491,000 to help cover savings that were projected but not achieved in the behavioral health services, and $910,103 for the drug management program. The OHCA's fiscal year 2001 budget request includes annualizing these funds.

Funding Proposals

- Governor Keating's Executive Budget request provides a $43 million increase in state reimbursements for Medicaid beneficiaries. The increase would provide a $97.8 million increase in federal matching funds.

- The Oklahoma Health Care Authority is requesting a $35.7 million increase in state funds for fiscal year 2001. This amount will fund the agency at the fiscal year 2000 level. The increase would provide a $113 million increase in federal matching funds. The Rural Healthcare Economic Development Initiative request is a $46.8 million increase that would provide $115.9 million in federal matching funds.

Both proposals increase provider reimbursement rates to 90% of the fiscal year 2000 Medicare fee schedule. Due to Medicaid waiver requirements funds must be increased in the fee-for-service program to increase funds in the managed care programs.

HB 1113, Three Free Prescription Medications, by Randy Beutler of the House and Frank Shurden of the Senate and **SB 1462** by Jim Maddox of the Senate and Bill Paulk of the House, direct the Health Care Authority to provide up to three free prescriptions per month to qualified Medicaid beneficiaries. The provision was deleted by Health Care Authority rules during the 1999 session and replaced with a two-tiered preauthorization system which created much controversy. *HB 1113 – Introduced in the Senate, Senate amendments pending. SB 1462 – General Order in the House.*

HB 1908, amends the Medicaid Project Integrity Act, by Mike Mass of the House and Gene Stipe of the Senate, corrects inconsistencies in state statutes concerning Medicaid fraud. The new language is consistent with federal law and other state statutes. *General Order in the Senate.*

HB 1916, Emergency Hospitals, by Randy Beutler of the House and Trish Weedn of the Senate, instructs the State Department of Health to apply to the Secretary of Health and Human Services of the federal government for any and all waivers, grants, or other assistance that would allow for the establishment of a program for enhanced reimbursement for services provided to Medicare beneficiaries in emergency hospitals in the rural areas of this state. The Health Care Authority shall establish a reimbursement methodology that will enhance reimbursement for services provided to Medicaid beneficiaries in these hospitals. *Title stricken. General Order in the Senate.*

HB 2062, by Clay Pope of the House and Bruce Price of the Senate and **SB 1552** by Trish Weedn of the Senate and Randy Beutler of the House, instruct the Oklahoma Health Care Authority to design and implement a reimbursement methodology for hospitals designated as critical access by the State Department of Health. Critical access hospitals are located in rural areas and have fifteen beds or less. *HB 2062 – Title stricken – General Order in the Senate. SB 1552 – Title stricken – House amendments read.*

HB 2077, Drug Utilization Review Board, by Scott Adkins of the House and Angela Monson of the Senate, adds one appointment to the DUR Board who shall be a Medicaid beneficiary and specifies that no staff or member of the Health Care Authority Board shall serve on the DUR Board. *Title stricken. General Order in the Senate.*

HB 2127, by Mike Mass of the House and Gene Stipe of the Senate, directs the Health Care Authority to eliminate certain inequities in Medicaid benefits between urban and rural beneficiaries including, but not limited to, the annual twelve day hospital inpatient limit, the monthly prescription and physician visit limit. *Title stricken. Introduced in the Senate – Senate Amendments pending.*

HB 2167, Chronic Conditions - Prescriptions, by Barbara Staggs of the House and Bernest Cain of the Senate, directs the Health Care Authority to allow a ninety-day supply to be counted as one prescription for patients with chronic conditions. The bill directs the Drug Utilization Review Board to define chronic conditions and allows pharmacists two dispensing fees for each ninety day prescription filled. *Title stricken. Engrossed in the Senate.*

SB 851, Evaluation of Services Report, by Ben Robinson of the Senate and Billy Mitchell of the House, directs the Health Care Authority to prepare a report on or before February 1 of each year evaluating the quality of health care services for recipients of Medicaid. The report shall include utilization of primary care services, preventive health services, acute care and emergency room treatment, management of chronic conditions and consumer satisfaction with access and quality of care. Special consideration shall be given to the aged, blind, and disabled population. The Authority may contract with an outside entity for preparation of the report. *Title striken. Introduced in the House - House amendments read.*

Hospitals

HB 1317, by Lloyd Fields of the House and Trish Weedn of the Senate, requires nonprofit hospitals to file a disclosure statement on health related entities. The county tax assessor would make the determination on the tax-exempt status. HB 1317 is a holdover bill from the 1999 session. *On General Order in the Senate.*

HB 2139, Needlestick Safety, by Bill Paulk of the House and Trish Weedn of the Senate, creating a task force to study needlestick safety and to develop uniform rules for adoption by appropriate licensure boards and regulatory agencies. The bill requires reporting requirements similar to OSHA. *Title striken. General Order in the Senate.*

SB 1583, Hospital Mergers, by Angela Monson of the Senate and Kevin Cox of the House, amends current law to require review of hospital mergers. *Title stricken. Died in the House Committee on Public Health.*

Public Health

HB 2125, Center for Addictive Behaviors, by Joe Eddins of the House and Maxine Horner of the Senate. The bill creates the Center for Addictive Behaviors and a revolving fund with no specified source of revenue. The Center staff shall be advised by an Addictive Disorders Council appointed by the Governor from a specified list of appropriate representatives with expertise in this area. The Center shall work with state agencies and state officials to evaluate programs, recommend changes for legislation, hold hearings and monitor the implementation of this act. *Title stricken. Died in the Senate Committee on Appropriations.*

HB 2375, Suicide Prevention, by Joan Greenwood of the House and Kathleen Wilcoxson of the Senate, permits the Commissioner of Health to establish a statewide surveillance system to track attempted suicides. The OSMA supports this measure. *Title stricken. General Order in the Senate.*

HB 2487, Oklahoma Prenatal Care Act, by Russ Roach of the House and Lewis Long of the Senate, states legislative intent that the state has a substantial interest in protecting children from harm resulting from abuse of drugs or alcohol by their mothers during pregnancy, both for the sake of the child and because of the potential cost to the state in providing medical care to such children. The bill creates a program to encourage and assist pregnant women who abuse drugs or alcohol to obtain prenatal care and substance abuse treatment services at one of the six appropriate state agencies. The measure goes further to require the Department of Mental Health and Substance Abuse Services to "prohibit all substance abuse treatment services administered by or contracted for by the Department from refusing to treat pregnant women." The measure provides misdemeanor penalties and fines for women refusing to seek treatment or comply with a treatment program and shields women who seek treatment from prosecution for any "illegal purchase or possession of a controlled dangerous substance" that occurred before she sought treatment. Further the bill provides that any medical provider or "other person" who suspects a woman is abusing drugs or alcohol would be required to report the matter to the State Department of Health. The OSMA has expressed concerns to Representative Roach about some of the bill's provisions and he is working with OSMA to address our concerns. *Title stricken. General Order in the Senate.*

HB 2660, by Ray Vaughn of the House and Mark Snyder of the Senate, originally authorized designation of do-not-resuscitate consent form on a driver's license. The OSMA Council on State Legislation and Regulation opposed this requirement. Representative Vaughn stated that the bill was not properly drafted. His intention was to authorize a notice of "advanced directive" on the driver's license. He amended the bill on the floor to reflect his original intent. The bill was also amended to repeal the state requirement for annual vehicle safety inspections. This provision will most likely be deleted in the Senate. *General Order in the Senate.*

SB 1469, Diabetes and Cardiovascular Disease Prevention, Education and Treatment Act, by Sam Helton of the Senate and Larry Rice of the House, requires the State Board of Health to promulgate rules necessary to carry out the provisions of the bill including but not limited to: providing funds to communities to develop or replicate successful education programs; collaborate with public, private and volunteer agencies and businesses to maximize state resources in the areas of prevention, treatment and education; provide or contract for self-management training for patients, families and communities in rural areas of low-access; and evaluate such programs as to outcomes and efficiency. The bill creates an Interagency Panel to work with the Department to implement the provisions of the bill. The OSMA supports this measure. *Title stricken. Dead.*

SB 1585, Health Information Systems, by Angela Monson of the Senate and Kevin Cox of the House is a shell bill. The authors' intent is to build upon the Health Information system in the State Department of Health. The OSMA and the Oklahoma Hospital Association are working with the authors on these proposals. *Title stricken, General Order House.*

Medicine Day

On Wednesday, March 22, 2000, the OSMA held their annual Medicine Day at the Capitol. It was a great success. About 150 physicians, spouses, and medical students attended the event. Medicine Day gives the physicians an opportunity to come to the Capitol and visit with their legislators regarding health care issues. Speaker of the House Loyd Benson, Senator Bernest Cain, Representative Jari Askins, and Governor Frank Keating's Cabinet Secretary of Health, Jerry Rieger, were the speakers for the event.

Legislative Communications and Grassroots

Legislative updates are provided on a weekly basis in the OSMA's publication *Week in Review*. Updates are also provided in the OSMA newsletter, and at the end of each legislative session a Legislative Report is published. Blast faxes are sent out periodically when OSMA members need to be notified to take action on legislation immediately. The OSMA physician database includes physicians' legislative districts on both the state and federal level. The OSMA continues to develop its grassroots efforts.

Subcommittees

The Chair of the Council on State Legislation appointed five subcommittees to study legislation and make recommendations to the full Council. These subcommittees included:

- Scope of Practice: John Leatherman, MD, Chair
- Other Issues: Sara Reed DePersio, MD, Chair
- Medicaid/OSEEGIB (Oklahoma State Education Employees Group Insurance Board)/Workers Compensation: James R. Claflin, MD, Chair
- General Health: Susan Harmon, MD, Chair
- Private Insurance: William O. Coleman, MD, Chair

Conclusions

The Oklahoma State Medical Association's presence in the state legislative arena has significantly been enhanced over the last several years due to 1) continued OSMA leadership and volunteer support; 2) the quality of the legislative issues, particularly in the area for patient advocacy initiated by the OSMA; and 3) the commitment of the OSMA to financially support the program by retaining the services of qualified executive and support staff, an experienced lobbying team, as well as providing other necessary resources, while staying within the budget allocated for the year for such activities.

We encourage all physicians to take advantage of the support services available through our association and through the American Medical Association's Grassroots Action Center.

During the OSMA Annual Meeting on Saturday, May 6th, a Legislative Luncheon is being sponsored by the Council on State Legislation, the Council on Governmental Activities, and OMPAC. During the luncheon, OSMA physicians and Alliance members will receive updates on the Patients' Bill of Rights, antitrust legislation, and other issues being debated on Capitol Hill. Participating on the federal panel will be John Montgomery, OSMA's Washington Lobbyist, Terry Carr, AMA Assistant Director of Congressional Affairs, and Cari O'Malley, AMA Regional Political Director. Discussing state legislative issues and providing updates on the use of Oklahoma's tobacco settlement funds will be OSMA Lobbyists, Lynne White and Dan Draper. All physicians and Alliance members are encouraged to attend this event.

2000 Budget Request: $154,000

Respectfully submitted,
Edward N. Brandt, Jr., MD, Chair

Annual Meeting Scrapbook (*continued*)...













Resolutions from the 94th OSMA Annual Meeting will be published in the August 2000 *Journal*

News

Oklahoma Physicians Honored by the University of Oklahoma College of Medicine

Nine Oklahoma physicians were honored by the University of Oklahoma College of Medicine with a Dean's Centennial Alumni Award, which recognizes OU College of Medicine alumni for outstanding service to the people of Oklahoma and to organized medicine in the state. Nominated by their county medical societies, the following physicians were recognized with a Dean's Centennial Award:

John A. Blaschke, MD, rheumatology, recently retired from the active practice of medicine. He was a 1950 graduate of the OU College of Medicine and a past president of the Oklahoma County Medical Society. He and his wife, Ruth, have been foster parents to 187 children and have received a commendation from the Oklahoma Department of Human Services recognizing their benevolence. Dr. Blaschke was nominated by the Oklahoma County Medical Society.



Physicians honored by the OU College of Medicine with Dean's Centennial Alumni Awards are (back row, left to right): John Wayne Flynn, MD; Robert White, MD; Gerald McCullough, MD; John Blaschke, MD; (front row, left to right) Danny Minor, MD; Billy Dotter, MD; Noel Miller, MD; Raymond Miller, MD; and Jasper Wheeler, MD.

Billy Dale Dotter, MD, practices surgery and family medicine in Okeene, and was a 1959 graduate of the OU College of Medicine. He has been a trustee of the college's alumni association and a member of the Governor's Health Study Committee. From 1991 to 1993, Dr. Dotter served as president of the Oklahoma State Medical Association, and was named the 1992 Family Physician of the Year by the Oklahoma Academy of Family Practice. Dr. Dotter was nominated by the Blaine County Medical Society.

John Wayne Flynn, MD, is a 1981 graduate of the OU College of Medicine. Dr. Flynn practices family medicine, obstetrics, and emergency medicine in Anadarko and currently serves as medical director for the county's Tactical Emergency Medical Service. Dr. Flynn has been county medical examiner for eight years, and served as medical examiner for four nights following the 1995 bombing of the Alfred P. Murrah Building in Oklahoma City. Dr. Flynn was nominated by the Caddo County Medical Society.

Gerald W. McCullough, MD, is a general surgeon in Norman and a 1954 graduate of the college. Dr. McCullough is the past president of the state chapter of the American College of Surgeons and of the Oklahoma Surgical Association, and he represented Oklahoma on the American College of Surgeons Board of Governors from 1986 to 1992. Dr. McCullough was nominated by the Cleveland-McClain County Medical Society.

Noel E. Miller, MD, is a 1959 graduate of the college and practices family medicine in Okemah. Dr. Miller served as a preceptor to OU medical students for several years and served four years on the college's admissions committee. He was elected a Charter Fellow in the American Academy of Family Practice in 1974; he and his wife, Bonnie Miller, MD, have been inducted into the Okemah Chamber of Commerce Hall of Fame. Dr. Miller was nominated by the Okfuskee County Medical Society.

Raymond D. Miller, MD, practices internal medicine in Okmulgee. A 1945 graduate of the college, Dr. Miller served as medical director of the Okmulgee County Health department for 45 of his 47 years of practice. Dr. Miller also served 39 years in the Air Force Reserve and has received a 50-year pin from the American Medical Association. Dr. Miller was nominated by the Okmulgee County Medical Society.

Danny Lee Minor, MD, of Tahlequah, is a general surgeon. Dr. Minor graduated from the college in 1971 and has done medical mission work in Nigeria, Kenya, Guatemala, and Ukraine. Dr. Minor was nominated by the Cookson Hills County Medical Society.

Oklahoma Physicians Honored (continued)

Jasper L. Wheeler, MD, has a general practice in Boise City. A 1952 graduate of the college, Dr. Wheeler has received an appreciation award from the county for his outstanding service. In 1991 he received a Presidential Citation from the Oklahoma State Medical Association. Dr. Wheeler was nominated by the Texas-Cimarron County Medical Society.

Robert G. White, MD, is a general practitioner in Sapulpa. A 1956 graduate of the college, Dr. White was a captain in the U.S. Air Force. His civic leadership includes serving as president of the Sapulpa Chamber of Commerce and two terms on the Sapulpa City Council. Dr. White was also named Citizen of the Year by the Chamber of Commerce and was nominated for this recognition by the Creek County Medical Society.

Dr. Jerry Vannatta, vice president for health affairs, associate provost, and executive dean of the College of Medicine, presented the awards during the annual OU College of Medicine Alumni Association banquet on May 6, 2000, in Oklahoma City. A majority of Oklahoma physicians are graduates of the OU College of Medicine, and other physicians selected from across the state will be recognized throughout the college's centennial year.

Calhoon Named OAFP Family Physician of the Year

Ed Calhoon, MD, of Beaver was chosen as the Oklahoma Academy of Family Physicians (OAFP) Family Physician of the Year. Dr. Calhoon graduated from the University of Oklahoma School of Medicine in 1951, opening his practice in Beaver in 1954, where he still sees patients. Dr. Calhoon also received the University of Oklahoma Health Sciences Center Physician of the Year Award in 1984, the Outstanding Oklahoma Medical Practitioner Community Service Award in 1980, and is a member of the Oklahoma Hall of Fame. He has been a member of the Oklahoma State Medical Association since 1953, serving as Association president from 1970 to 1971.



Dr. Ed Calhoon, OSMA past president and member of the Oklahoma Hall of Fame, was recently named OAFP Physician of the Year.

Oklahoma Physician Named to Cancer Liaison Program

Glen Hanson, MD, of Shawnee, has recently been appointed to a three-year term as Cancer Liaison Physician as part of the Commission on Cancer of the American College of Surgeons. Dr. Hanson joins the national network of more than 1,800 volunteer Cancer Liaison Physicians who provide support to Commission on Cancer activities.

"Jawbones" and "Sawbones" Tee It Up for Charity

The Oklahoma County Medical Society and the Oklahoma County Bar Association co-sponsored the Jawbones-Sawbones Golf Tournament held May 19 at Coffee Creek Golf Club in Oklahoma City. Thirty-six golfers participated in the tournament, which raised approximately $3,500 for *Oklahoma Lawyers for Children*. Robert L. Wilson, MD, and Jake Jones, Attorney at Law, served as tournament coordinators.

OSMA member physicians played on each of the top three teams in the tournament: Jeff Scott, MD, Danny Smith, MD, Robert L. Wilson, MD, and Rob Wilson took first place; the second place team included Mark Johnson, MD, G.W. "Butch" Schoenhals, MD, Jake Jones III, Attorney at Law, and Scott Peck, Attorney at Law; and J. Christopher Carey, MD, Kent Webb, MD, John Holcraft, and David Johnson took third place. Charles Monnet, MD, won the award for closest to the pin, and David Korber, MD, won for longest drive.



Two jawbones and a sawbone
Pictured, from left to right, are attorneys Scott Peck and Jake Jones and Dr. Mark Johnson. The trio, along with Dr. G.W. "Butch" Schoenhals, placed second in the tournament.

www.okmed.org

New Home to the OSMA Web Site

As part of its effort to continuously improve communication with its members, the OSMA's Web site has been given a new look and a new name. Under the direction of the Council on Professional Communications, OSMA staff will be reviewing and revising the Association's Web site on an ongoing basis. The new Web site address is: www.okmed.org. Please use the form below to provide us with your current mailing and e-mail addresses to assist us in establishing our secure members-only side to the site. See you on the Web!

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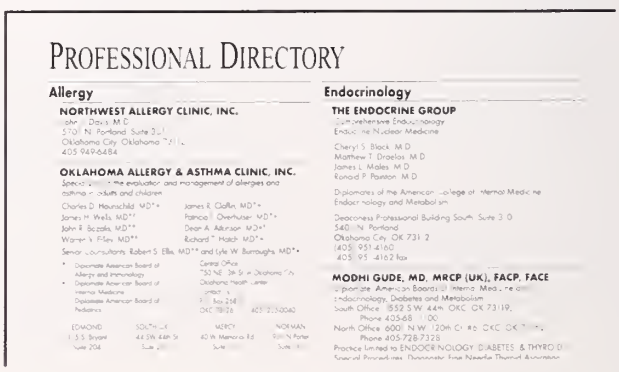
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All manuscripts should approximate the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual of Style,* 9th Edition. An abstract of 150 words or less should accompany each manuscript, stating the exact question considered, the key points of methodology and success of execution, the key findings, and the conclusions directly supported by these findings.

Bylines may contain no more than **six** (6) names and shall include only those individuals who can attest that they have contributed to the conception and design or analysis and interpretation of data, drafting the article or revising it critically for important intellectual content, and the final approval of the version to be published. Other contributors may be recognized in an acknowledgment.

All references must be listed in their order of appearance in the manuscript, and must conform to the style used in both the *Journal* and *JAMA* (for example: Richter RW, Farlow MR. Recent advances in the treatment of Alzheimer's. *J of the Okla State Med Assoc.* 1998;91(8):431-437.). Footnotes, bibliographies, and legends for illustrations should appear on separate sheets.

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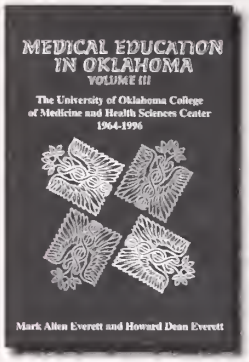
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In Memoriam

1999

Hyman J. Drell July 15
Lee Bailey Word, MD July 22
Dave B. Lhevine, MD July 31
Michael Allan Houghton, MD August 16
Webb M. Thompson, Jr., MD August 20
Perry A. Lambird, MD August 25
Nolen L. Armstrong, MD September 12
George R. Randels, MD October 2
George B. Carter, MD October 7
John Robert DeBiase, MD October 17
Theodore Turnbull, MD October 19
Sol Wilner, MD October 31
Malcolm Horne, MD November 3
William Clark Cheek, MD November 11
Bill B. Elrod, MD November 17
Donald E. Johnson, MD November 18
Allen E. Greer, MD November 19
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Norman A. Cotner, MD December 3
Alan Knight Braly, MD December 9
Wilson David Steen, PhD December 12
James Thermon McInnis, MD December 18
Douglas Lyons Polk, MD December 19
Thomas S. Llewellyn, III, MD December 26
John Preston McDaniel, MD December 27
Joe Earle Tyler, MD December 31

2000

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James L. Nicholson, MD February 3
Leo Meece, MD February 5
Homer A. Ruprecht, MD February 6
William G. McCreight, Sr., MD March 10
Armond H. Start, MD March 30
Billy E. Blevins, MD April 3
Willis E. Lemon, MD April 21
Roy A. Lawson, MD April 22
Benjamin F. Gorrell, MD April 29
Adolph N. Vammen, MD May 8
Ross P. Demas, MD May 15
William C. Stone, MD May 18
Hubert M. Anderson, MD May 22

Obituaries

Ross P. Demas, MD
1922-2000

Ross P. Demas, MD, died May 15, 2000. Born in Ponca City on July 12, 1922, Dr. Demas received his medical degree from the University of Oklahoma School of Medicine in 1946. From 1954 to 1956, Dr. Demas served in the United States Army, holding the rank of First Lieutenant at time of discharge. Dr. Demas was a life member of the Oklahoma State Medical Association since 1984.

William C. Stone, MD
1935-2000

William C. Stone, MD, died May 18, 2000. Dr. Stone was born in Denver, Colorado on January 7, 1935, and received his medical degree from the University of Oregon in 1964. From 1964 to 1975, Dr. Stone served active medical military service in the United States Navy. In 1999, Dr. Stone was named a life member of the Oklahoma State Medical Association.

Hubert M. Anderson, MD
1916-2000

Hubert M. Anderson, MD, died May 22, 2000. Born July 12, 1916, in Oklahoma City, Dr. Anderson received his medical degree from the University of Oklahoma School of Medicine in 1942. Dr. Anderson received a Bronze Star for his military service, which included his service as a Battalion Surgeon in World War II. Dr. Anderson was a member of the Oklahoma State Medical Association.

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Course offerings from OSMA Accredited Institutions

Duncan Regional Hospital: Amy Wade 580/251-8643

July	20	OFMQ National Projects	Noon	1 hour

Integris Baptist Medical Center: Donna Schoenfelder 405/949-3284

July	07	Tumor Board	7:00am	1 hour
July	10	"National Quality Improvement Projects"	7:00am	1 hour
July	13	"Ligament Injuries of the Wrist"	5:30pm	1 hour
July	14	Cancer Conference	7:00am	1 hour
July	18	"National Quality Improvement Projects"	7:00am	1 hour
July	21	Tumor Board	7:00am	1 hour
July	28	Tumor Board	7:00am	1 hour

Integris Southwest Medical Center: Johnathan Stotler 405/636-7087

July	06	Cancer Conference	12:15pm	1 hour
July	12	COX II Inhibitors	12:15pm	1 hour
July	13	Cancer Conference	12:15pm	1 hour
July	18	Prospective Breast Care Conference	12:15pm	1 hour
July	19	Pain Management	12:15pm	1 hour
July	20	Cancer Conference	12:15pm	1 hour
July	25	Pediatric Series: Airway Infections in Children	12:30pm	1 hour
July	26	"Anti-Hypertensives"	12:15pm	1 hour
July	27	Cancer Conference	12:15pm	1 hour

Mercy Health Center: Debbie Stanilla 405/752-3806

July	06	"The Changing World of Diabetes Management"	12:15pm	1 hour
July	11	NeuroScience Institute Lecture Series	7:00am	1 hour
July	12	Tumor Board: Angiogenesis Inhibitors	7:00am	1 hour
July	13	"Alzheimer's Disease: Diagnosis/Management"	12:15pm	1 hour
July	20	Antiviral Update	12:15pm	1 hour
July	27	"State and National Trends in Managed Care"	12:15pm	1 hour

St. John Medical Center: Gail Hilst 918/744-2875

July	06	Critical Care Conference: Bites and Stings	Noon	1 hour
July	11	Critical Care Conference: DKA	Noon	1 hour
July	13	Critical Care Conference: Endocarditis and Line Infections	Noon	1 hour
July	18	Critical Care Conference: Tubes and Lines	Noon	1 hour
July	20	Critical Care Conference: Management of Acute Coronary Syndrome	Noon	1 hour
July	27	Critical Care Conference: Hymolytic Anemia	Noon	1 hour

Valley View Regional Hospital: Belinda Runnells 580/421-1467

July	17	"New Treatment for Weight Loss/Obesity"	Noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator at 405/843-9571 or 800/522-9452.

On the Road with the OSMA Alliance...

Members of the OSMA Alliance traveled to Chicago this June for the AMA Alliance Annual Meeting at The Drake Hotel. The highlight of the meeting was the installation of Susan Paddack, of Ada, as AMA Alliance President.



OSMA Alliance members perform a skit during the Saturday evening dinner held with Oklahoma's AMA Delegation honoring Susan Paddack.



Susan Paddack (right) with her mother, Mrs. Onita Leigon, during the AMAA reception honoring 1999-2000 AMAA President Ann Hansen and 2000-2001 AMAA President Susan Paddack.



Past presidents of the OSMA Alliance in attendance included: (from top, left to right) Barbara Jett, Camille Harrison, Sherry Strebel, Mary Ann Deen, Jan Storms, Julie Weedn, Karen Mask, Nora White, "K" Caldwell, Cheryl Baker, and Susan Paddack.



Dr. Bruce Storms (far left) and his wife, Jan, congratulate Susan during the AMAA reception in her honor.



Barbara Jett (far left), who was installed as an AMAA Field Director, stops for a photo with AMAA Executive Director Hazel Lewis (second from left), Sherry Strebel (second from right), and Andrea Jones (far right) before going on to the next Alliance activity.

THE LAST WORD

Durable Power of Attorney for Health Care Available

A form designed to make end-of-life planning easier for Oklahomans has been developed and is now available through the Aging Services Division of the Oklahoma Department of Human Services. Beginning immediately, the new form known as the Durable Power of Attorney (with Health Care Powers Only) is available free to the public.

"With this form Oklahomans may appoint a family member or friend as agent to make health care decisions for them if they become incapacitated," explained Richard Ingham, legal services developer for Aging Services Division. "Now families have all three documents needed for end-of-life planning—the Advance Directive, Oklahoma Do-Not-Resuscitate (DNR) Consent Form, and the Durable Power of Attorney (with Health Care Powers Only) available free."

Ingham emphasized that in Oklahoma it is necessary to appoint an agent to make health and medical care decisions for an incapacitated patient because the powers of a proxy appointed under an Advance Directive are limited to life-sustaining treatment decisions. Also, an agent appointed by this form can serve as the patient's representative to sign DNR Consent Form at the appropriate time. "The form also serves as a reminder to family members and health care providers that the agent's acts are to be honored as an expression of the patient's legal right to manage his or her own health care," Ingham said.

The form is available by calling toll-free the Department of Human Services warehouse, 877/283-4113. Ingham is available without cost to explain the new form to health care providers and community groups. He can be contacted at 405/522-3069.

New Guideline on Treating Tobacco Dependence Released

The U.S. Public Health Service has released a new guideline, "Treating Tobacco Use and Dependence: A Clinical Practice Guideline," to provide health care professionals with information and tools to help patients quit using tobacco. The guideline concludes that tobacco dependence treatments are both clinically effective and cost-effective relative to other medical and disease prevention interventions, and urges health care insurers and purchasers to include, as a covered benefit, the counseling and pharmacotherapeutic treatments identified as effective, and to pay clinicians for providing tobacco dependence treatment. For information, call 800/358-9295 or visit http://www.surgeongeneral.gov/tobacco/default.htm.

AMA Council on Medical Education Approves New Activities for Credit

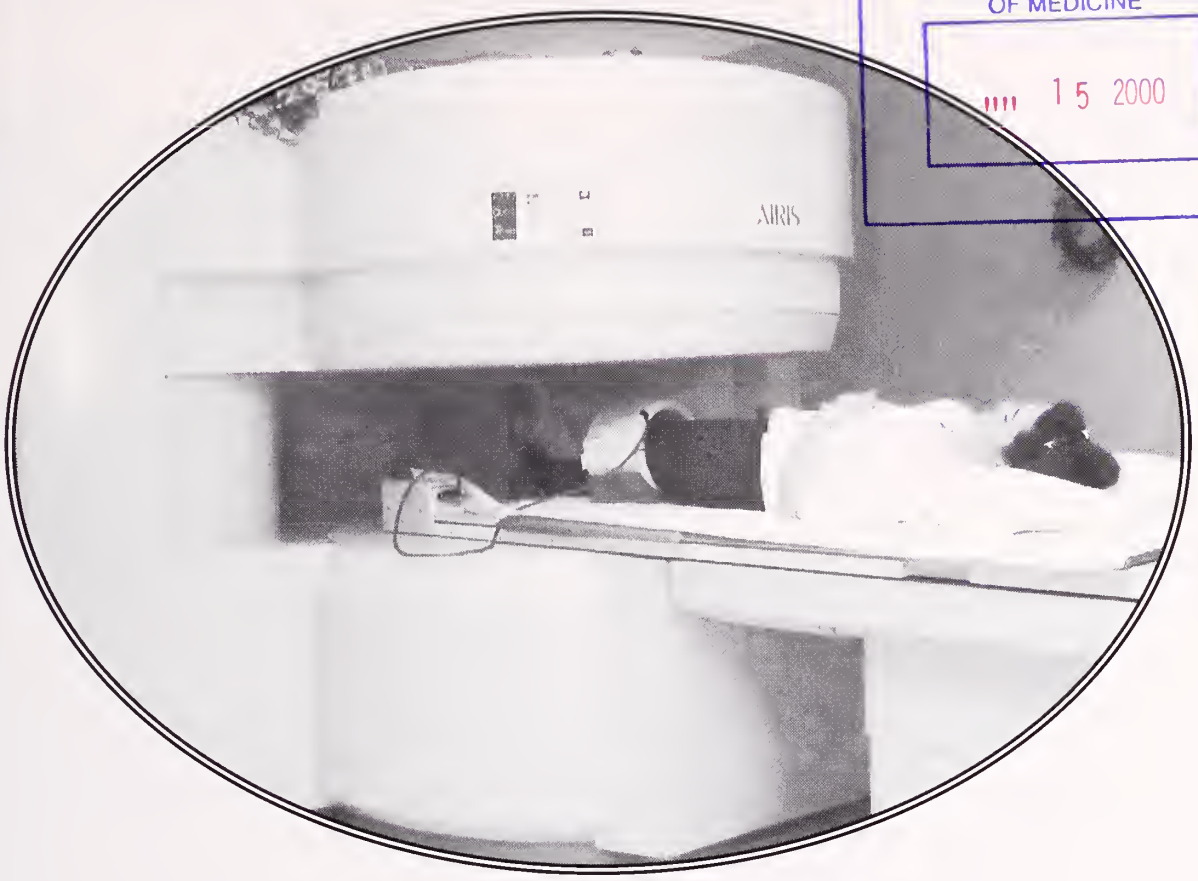
The AMA Council on Medical Education took several actions regarding Category 1 credits for the AMA Physicians Recognition Award (PRA), including the addition of several activities for the PRA application form: articles published in peer-reviewed journals; poster preparation for an exhibit at a medical meeting and published abstract; teaching (eg, presentations); specialty board certification and maintenance of board certification; and medically related degrees. Letters have been sent to state licensing boards informing them of these credit changes and requesting that they accept this credit in connection with their reporting requirements. For copies of the PRA information booklet or the PRA application, please contact the AMA at 312/464-4664.

OSDH Advising Parents to Avoid the "Back to School" Rush

The Oklahoma State Department of Health is encouraging parents to avoid the back to school rush and have their children immunized now for the 2000-2001 school year. For information about the immunizations required for school entry and education level, parents can contact their local county health department or the Oklahoma State Department of Health Immunization Division at 405/271-4073.

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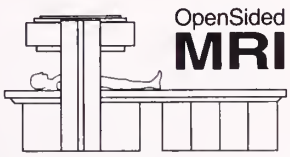
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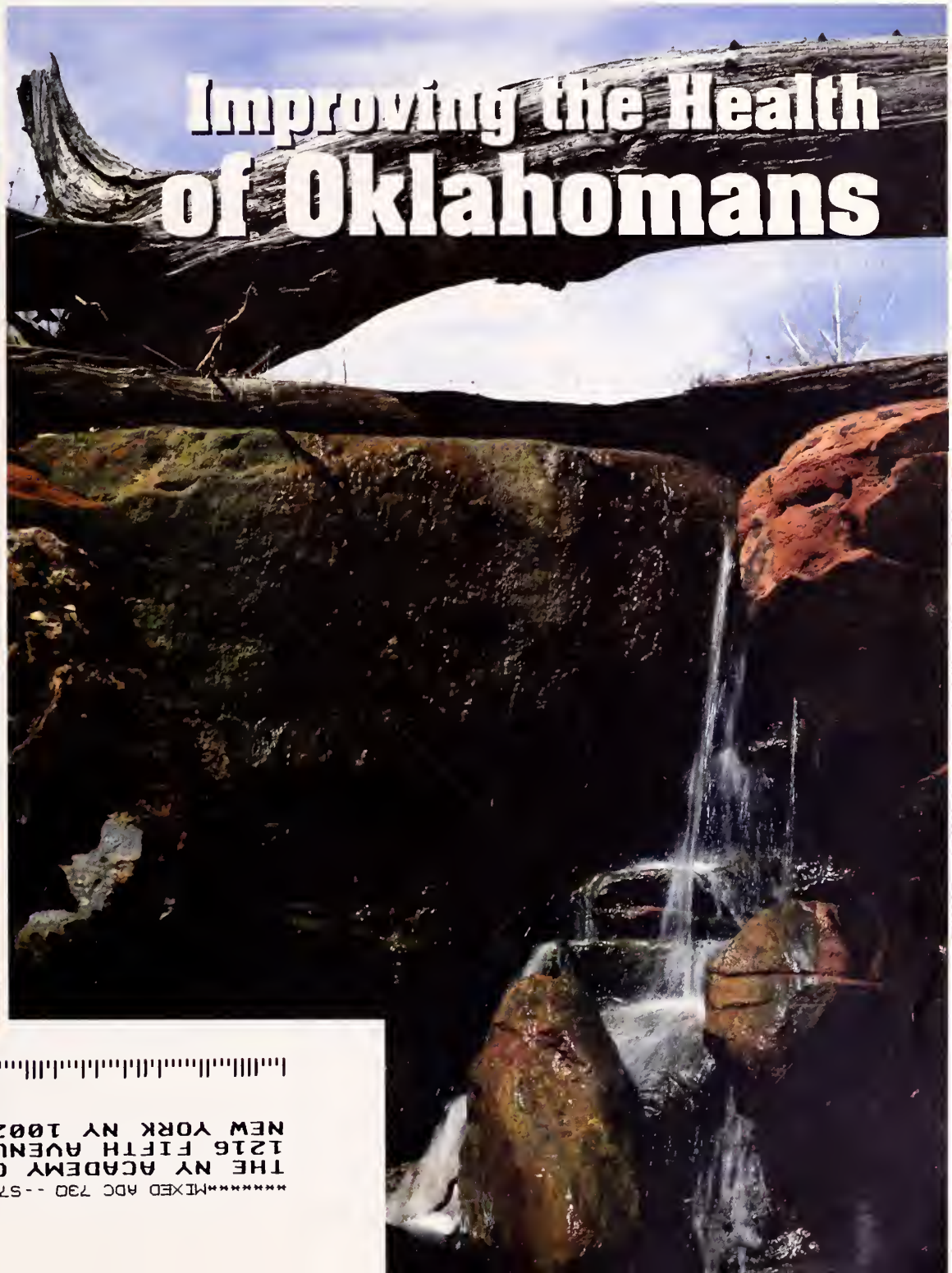
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OKLAHOMA STATE MEDICAL ASSOCIATION



INSIDE:

- Prostate Cancer Treatment 391
- Doctor's Diary 411
- Resolutions of the 2000 OSMA Annual Meeting 414
- News 417

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OKLAHOMA STATE MEDICAL ASSOCIATION

AUGUST 2000 VOL. 93, NO. 8

EDITORIAL

Much Is Required... 387
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE

The AMA: Serving Oklahoma Physicians 389
ROBERT J. WEEDN, MD, DUNCAN

SCIENTIFIC

Prostate Cancer Treatment with Ultrasound-Guided Transperineal Brachytherapy: Analysis of the Treatment Results of our First 150 Patients 391
GARY LARSON, MD, OKLAHOMA CITY; NICHOLAS PAPPAS, MD, OKLAHOMA CITY; BASEL HASSOUN, MD, OKLAHOMA CITY

SCIENTIFIC

Improving the Health of Oklahomans Through Clinical Prevention, Part II: Screening to Identify Early-Stage Disease and Risk Factors 397
JAMES M. CRUTCHER, MD, MPH, OKLAHOMA CITY; DAVID J. DEROSE, MD, MPH, SULPHUR; SARA REED DEPERSIO, MD, MPH, OKLAHOMA CITY

DOCTOR'S DIARY

The Nodule 411
RAYMOND J. DOUGHERTY, MD, OKLAHOMA CITY

ANNUAL MEETING

Resolutions of the 2000 OSMA Annual Meeting 414

NEWS

Eaton Named Physician of the Year, 417...Woods Named to Physician Manpower Training Post, 417...GHB and GBL Now Classified Substances, 417...OSMA Web Site Offers Password Protection, 417...Domestic Terrorism Exercise Held in Oklahoma City, 418

DEPARTMENTS

From the Oklahoma State Department of Health, 419...Obituaries, 423...In Memoriam, 423...CME, 426...Alliance, 427...The Last Word, 428



ABOUT THE COVER

Oklahoma's Turner Falls, photographed by Robert Smith, MD.

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Much is Required...

A significant part of my religious tradition includes the notion of giving back. "To whom much is given, much is required." If you research this teaching and tradition, you will find that it is included in many of the world's religions...as a core teaching...as a model to live by...as a walk to walk.

As a profession, medicine has traditionally accepted this responsibility. It is part of the approach that we collectively take in practicing our science. On the surface it sounds fairly simple; at the core it can be extremely hard to achieve.



When was the last time that you tried to recruit for a fund raiser, or for the volunteer clinic in your community? As clinicians we are busy; we have jam-packed calendars and we are experts at excuse. We have developed our excuse abilities to the point of disintegrating a long-held tradition in our profession.

How has this happened?

One approach has been to find practice sites that are divorced from the communities in which we live. The advantage: it does not take you three hours to buy groceries, because no one knows you in the morass of humanity. The down side: we guiltlessly excuse ourselves from community responsibilities, from those things that have been traditionally given back to the community without compensation or even recognition as an "added value" service.

It is the time of year when physicians are called upon to provide sports physicals. I will not discuss the evidence base regarding this annual exam of healthy athletes, as it would show that this endeavor is a waste of time. This is often the problem when we look at interventions from a strictly scientific perspective. Sports exams are an opportunity to interact with a portion of our community that does not typically have contact with physician role models.

I think back to my own experience with physicians during sports exams.

Old Doctor Sheets would not let me out of the clinic until he had a urine specimen in the bottle. I evidently had stage fright, because it took me three hours to "perform." I can remember thinking, "this is a pretty cool job, that doctor must know lots of things and see lots of weird stuff." Since this was the only interaction I had with a physician during my school years, it served as a catalyst for me to explore further.

The physician serves as a role model to someone with each step and action that we take.

The motivation to volunteer and serve is difficult to teach. At our local community clinic, if I go with the attitude that it is just something I must do—a chore—then I miss the personal advantage or blessing of giving. It sure makes the time go by more quickly when I am able to check my attitude at the door. When hammering on a Habitat for Humanity house, I must approach the process with an attitude of learning something for which I have not been trained.

Each time we give away a bit of ourselves, we get a greater return on our investment. But if it were this easy, everyone would be contributing their service, and we all know that this is not the nature of human beings.

The forced indentured service that is subtly foisted upon us by the federal government (Medicare), state government (Medicaid), and private insurance companies takes away much of the motivation for giving something back. It develops in each of us an attitude of abuse. We allow ourselves to become the victim. We end up generalizing our frustration with the system by not giving back anything.

It is short-sighted, because it really only frustrates us further...

One of the best explanations of a life of service was given by an accountant friend of mine who recently received an award for his service to his community. He told the story of his father teaching the value of service. He taught that service was the rent we pay for the space we occupy on this earth. My accountant friend said that it didn't dawn on him, until he was an adult, that there are a lot of folks out there not making their rent payments.

Maybe it is time to quit seeing ourselves as the victims and start paying our portion of the rent...



J. Michael Pontious, MD
Editor-in-Chief

"The motivation to volunteer and serve is difficult to teach. At our local community clinic, if I go with the attitude that it is just something I must do—a chore—then I miss the personal advantage or blessing of giving."

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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President's Page

The AMA: Serving Oklahoma Physicians

Each year, your OSMA president joins the AMA delegation at both the AMA Annual Meeting in June and the Interim Meeting in December. Although I've always been a supporter of the AMA, believing that we as physicians need a national organization to represent us, I have on occasion been disgruntled by what seems to be an organization that was not representing me adequately or effectively.



This year I had the opportunity to attend the AMA National Leadership Conference in March as president-elect, and then attended the AMA Annual Meeting in June as your president. I must say that I've come away from these experiences with a heightened awareness and respect for what the AMA is trying to accomplish for you and me as practicing physicians. I have a greater understanding of how AMA policy is developed and implemented. The process is not always perfect, but just as our OSMA House of Delegates and Board of Trustees function as a representative democracy, so does the AMA.

First and foremost, the AMA represents just under 300,000 physicians as the only national physician organization with enough clout to be effective advocates for both physicians and their patients. We may debate the effectiveness of the AMA from time to time, and like all of us, the AMA can and does make mistakes—but there is no real alternative.

Certainly specialty societies have a national presence, but they simply do not have the broad-based membership numbers to have the same impact as the AMA. The AMA is almost always called to the negotiating table for input. Passage of this year's major health care legislation, the Patients' Bill of Rights (Norwood-Dingle bill) and the Physicians' Antitrust Relief bill (Campbell-Conyers bill), in the U.S. House of Representatives were major victories for the AMA—and the battle for passage in the Senate is ongoing. The 5.4% Medicare payment update, the maximum possible under the law and the biggest across-the-board increase since 1992, would not have happened without the AMA in your corner.

The "Is it good medicine?" campaign has been successful in demonstrating and promoting AMA and physician/patient advocacy referable to public health issues throughout the United States. In addition to the national advocacy role, the AMA provides a host of traditional member services that I will not list but have found to be quite useful from time to time, not the least of which are the *Journal of the American Medical Association* and *AMA News*, that provide scientific and professional information over a broad range of topics frequently not available in the specialty literature.

I learned that the AMA meetings are not vacations and that your delegates are extraordinarily committed to your welfare and the welfare of your patients. The AMA meetings are sunrise-to-past sunset endeavors attacked by your delegation in a very organized, methodical fashion under the capable leadership of Dr. Jay Gregory. Your delegates spend two weeks away from their practices each year to represent you and I've seen that they do so effectively, especially when joining together with delegates from Arkansas and Missouri in the Heart of America caucus—which they are currently trying to expand into a super-caucus that would include the Texas and North Central caucuses.

Although unique in our unified status arrangement amongst all states except Mississippi, this status does provide real benefits to you—most notably the reduced AMA dues, which are $120 less than regular membership, and increased representation. Oklahoma's unified status provides us with two additional delegates and two additional alternate delegates to cover the numerous committee meetings that occur during the AMA Annual Meeting. The interaction that takes place at these meetings creates a

"The AMA meetings are sunrise-to-past sunset endeavors attacked by your delegation in a very organized, methodical fashion under the capable leadership of Dr. Jay Gregory."

networking resource for the OSMA as we deal with the problems we face here in Oklahoma.

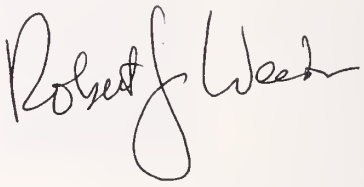
No organization can represent its membership without input and participation. I believe the AMA and our unified status does provide value for you, for the OSMA, and for your county medical society. Obviously, this value is lessened if you do not take advantage of your membership.

My hat is off to our AMA delegates and alternate delegates who serve us so well. The next time you see one of our Oklahoma delegation members, you might say "thanks" for their commitment on our behalf.

Delegates:
Jay A. Gregory, MD
Jack J. Beller, MD
Mary Anne McCaffree, MD
Norman Dunitz, MD
Gary Strebel, MD
William H. Hall, MD
W. Frank Phelps, MD
Bruce Storms, MD

Alternate Delegates:
William Bernhardt, MD
Susan Harmon, MD
Carl T. Hook, MD
Mukesh Parekh, MD
Varsha Sikka, MD
Jennifer Trottman, MD
Mayo Gilson, MD
Kautilya Mehta, MD

Although idealistic, I believe that we will best be served if we approach each other and our organization in the style of the Three Musketeers—"All for One and One for All."



Robert J. Weedn, MD
OSMA President

Prostate Cancer Treatment with Ultrasound-Guided Transperineal Brachytherapy: Analysis of the Treatment Results of our First 150 Patients

Gary Larson, MD; Nicholas Pappas, MD; Basel Hassoun, MD

This paper presents outcome data from our initial 150 patients who had received all or part of their radiation dose for the treatment of adenocarcinoma of the prostate using permanent radioactive seed implantation. Median follow-up for this group is now three years. Fifty-six patients had tumors with gleason scores of 7 or greater, and 94 had gleason scores of 6 or less. The average age was 67 (range 42 to 79). Ninety-five percent have maintained biochemical control of their disease (PSA level of 1.0 or less) since the time of implant. Questionnaires were sent to all patients to assess quality of life issues. Fifty-eight percent have maintained potency. Ninety-eight percent of those surveyed said they would recommend this treatment to other men with prostate cancer. Our results support the findings of other published series. Ultrasound-guided transperineal brachytherapy is a well-tolerated procedure with excellent cancer control rates and should be considered as a treatment option in men with localized prostate cancer.

Introduction

In the United States this year, 180,000 men will be diagnosed with adenoeareinoma of the prostate, 2,000 of whom will live in Oklahoma.[1] Curative treatment for localized prostate eaneer is possible using surgery or radiation therapy.[2] Radiation therapy ean be delivered externally, using a linear aeeelerator, or internally, using radioaetive isotopes. Braehytherapy refers to the short distanee irradiation of eaneer by plaeement of radioaetive sourees within tissues harboring cancer cells. This is perhaps the oldest method of eaneer therapy using ionizing irradiation and dates from the early 1900s.

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Braehytherapy as a treatment for prostate eaneer using radioaetive iodine seeds (I-125) enjoyed a brief period of popularity in the mid-1970s. Seeds were implanted into the prostate following surgieal exposure of the gland under direct visualization using a "freehand teehnique." It was diffieult to aehieve an aeeeptable distribution of sources within the treated volume of tissue using freehand implantation. Excessive gaps between seeds resulted in "eold spots" where eaneer eells were not sterilized. Bunehing together of seeds resulted in "hot spots" where tissue neerosis oeeurred. This procedure was eompletely abandoned by the latter part of the 1970s due to poor eure rates and excessive eomplieations.[3,4]

Braehytherapy for the treatment of prostate eaneer has enjoyed a resurgenee in popularity during the last ten years due to the advanees in ultrasound teehnology allowing preeise plaeement of sourees. Seeds are now implanted under direet visualization using real time trans-reetal sonography, allowing plaeement of eaeh seed within millimeters of its planned position. Published series now report ten-year eure rates eomparable to those obtained with radical prostateetomy.[5,6] High eure rates can be obtained only by proper patient seleetion and eareful treatment planning.[7-13]

We began using ultrasound-guided transperineal braehytherapy for the treatment of men with elinieally loealized prostate eaneer in 1994. This report deseribes our clinieal experienee with our first 150 patients.

The Evolution of our Treatment Protocol

There is a large body of published data on the treatment of careinoma of the prostate using

brachytherapy. Series vary as to their choice of isotope, the use of androgen blockade, and criteria for combining brachytherapy with external beam irradiation.[14-18] We chose to model our treatment protocol after the one used at the Northwest Tumor Institute in Seattle, due to the size of their series and the duration of long-term follow-up.[3-5,7,11,19] Although we used their guidelines as a starting point, a number of considerations have shaped the development of our present protocol:

1.) What is the risk of extraprostatic extension of cancer? Various clinical parameters have been studied as to their ability to predict extracapsular extension of prostate cancer.[13,20] A review of prostatectomies performed in Oklahoma during 1997 showed a 41% incidence of positive pathologic margins in patients thought to have disease confined to the gland.[21] Just as surgery fails to cure patients when malignant cells are left behind, radiation therapy fails when cancer cells receive doses insufficient for complete sterilization. Our first patients were treated with implant alone if they were felt to have organ-confined disease. The majority of our recurrences resulted from treating what we would now call "high risk" patients with implant alone. About one year into our brachytherapy experience, a number of papers began to appear defining risk factors for extraprostatic extension of tumor (ie, extension beyond the high dose volume of irradiation resulting from seed implantation).[3,5,8,12,13] High-risk patients now receive 4500 cGy external beam radiation therapy prior to their implant in order to increase the volume of periprostatic tissue receiving a tumoracidal dose of irradiation. Since this modification of our protocol was added, the high-risk patients now have a prognosis approaching that of the low-risk group. High-risk patients are those with one or more of the following attributes:

a.) Initial PSA value greater than ten.
b.) Gleason score of seven or greater.
c.) Clinical stage T2b or T3 disease.
d.) Multiple positive sextant biopsies.

2.) What is the role of pre-irradiation androgen blockade? Several randomized studies have compared the results of external beam irradiation alone versus a combination of androgen blockade followed by external beam irradiation for patients with locally advanced prostate cancer. A statistically significant improvement in five-year disease-free survival was demonstrated in the groups receiving pre-irradiation androgen blockade.[16,17] This data has been extrapolated to earlier-stage prostate cancer. The majority of patients receiving external beam radiation therapy today receive some form of androgen blockade (an LHRH agonist with or without an antiandrogen) for two months before beginning irradiation. Many of the published series of prostatic brachytherapy patients have likewise been pretreated with some form of androgen blockade prior to implant, although this has not been studied as an independent variable. Whether or not this really has the effect of potentiating the cytotoxic effects of ionizing radiation on prostate cancer cells, it has generally become the standard of care. All of our patients have received pre-irradiation treatment with an LHRH agonist (leuprolide or goserilin) with or without an antiandrogen (flutamide or bicalutamide). Besides the theoretical value of this neo-adjuvant treatment, it has several practical benefits:

a.) Androgen blockade causes shrinkage of the prostate and improves obstructive symptoms. (Some patients present with impaired bladder outflow and most develop it transiently due to prostatic edema following brachytherapy.)
b.) The smaller the prostate, the fewer the number of radioactive seeds required to encompass it within a tumoracidal dose volume. The smaller the number of seeds, the lower the probability of side effects.
c.) It arrests the growth of prostate cancer cells while patients are undergoing brachytherapy treatment planning and the seeds are being obtained from the manufacturer.

Our present protocol allows for treatment of patients without androgen blockade if they are otherwise good candidates for the procedure but are unwilling to accept the side effects of hormonal manipulation (fatigue, hot flashes, loss of libido, weight gain).

3.) Are there contraindications to prostatic brachytherapy? Early published reports demonstrated an unacceptably high rate of stricture formation and incontinence in brachytherapy-treated patients who had prior transurethral resection of the prostate (T.U.R.P.).[4] More recent studies reported a lower risk with proper selection criteria.[22] None of our initial 150 patients had a prior T.U.R.P. due to the reported incidence of complications in such patients. Our present protocol, however, allows inclusion of post-T.U.R.P. patients if they have only a small

intraprostatic tissue defect demonstrated on ultrasound. The possible complications are thoroughly discussed with these patients before they make a decision about proceeding.

Patients whose gland is greater than 50 cc in volume after androgen blockade have a high risk of prolonged urinary outlet obstructive symptoms. They may have repeat sonography following an additional period of androgen blockade to see if their gland shrinks below the 50 cc volume, or be counseled to consider other treatment options. Some of our early patients had very large glands and constitute the majority of our long-term urinary complications.

Obviously, candidates for brachytherapy must meet the same generally accepted guidelines for definitive treatment as patients considering other forms of curative therapy (ie, radical prostatectomy or definitive external beam irradiation). They must have an acceptable risk for anesthesia and a life expectancy of at least five years.

4.)What form of brachytherapy should be used? Prostate brachytherapy has been performed with a variety of both permanent and temporary radioactive sources. Those most commonly used today include Iodine-125 and Palladium-103 for permanent implants, and Iridium-192 for temporary implants. Iridium-192 emits gamma rays with energies up to 612 KeV, and a significant radiation dose occurs well outside of the patient, necessitating patient isolation during treatment. Patients must be hospitalized for two to three days for prostate brachytherapy using iridium.

Iodine-125 has a half life of 60 days and a gamma ray energy of 27 KeV. Palladium-103 has a half life of 17 days and a gamma ray energy of 21 KeV. Because of their low gamma ray energies, there is almost no exposure to others from the intraprostatic seeds, hence their safety for permanent implantation. Patients can be discharged the day of the procedure. Occasionally, patients with a large number of implanted seeds are instructed to avoid close contact with pregnant women or young children for a set period of time, based on radiation dose measurements taken just after the procedure. There is never enough exposure to warrant restrictions on contact with non-pregnant adults.

Ninety percent of the prescribed radiation dose is delivered within seven weeks using palladium seeds, while it takes six months for this to occur with iodine. In general, therefore, palladium seeds are used for the more poorly differentiated tumors (gleason 7 and higher) while iodine is used for the lower grade tumors (gleason 6 and less). According to Blasko, this choice of isotope versus tumor grade was based on radiobiologic considerations and has not been the subject of any clinical trials (personal communications, June 1997). Some centers use iodine or palladium exclusively and report comparable clinical outcomes. For our protocol, we have chosen to follow the recommendations of the group at the Northwest Tumor Institute, using Iodine-125 for gleason scores <7 and palladium for those 7 and greater.

Methods

Each patient was seen by the urologist and the radiation oncologist for consultation prior to deciding his choice of therapy. Many patients were self-referred for brachytherapy, having heard of it in the lay press or on the Internet. All potentially curative treatment modalities were discussed with each patient. Younger patients were encouraged to consider prostatectomy. Patients with prior T.U.R.P.s were encouraged to consider surgery or external beam radiation therapy. Many of the self-referred patients came to these consultations with unrealistic expectations, due to biased reports in the lay press that minimized the side effects of the procedure. All were thoroughly counseled regarding the expected benefits, expected side effects, and potential complications, and encouraged to take an adequate amount of time to make their decision.

When the patient had decided on brachytherapy as definitive treatment, the urologist began androgen blockade. After two months, transrectal sonography was performed with cross-sectional scans obtained at 5 mm intervals from the base of the gland to its apex for the purpose of brachytherapy treatment planning. High-risk patients began external beam irradiation at this point and received 4500 cGy in 25 fractions over five weeks. Their implant was usually scheduled three weeks after the completion of external beam treatment. Patients who were good candidates for brachytherapy as monotherapy were scheduled for implant about three weeks after their ultrasound mapping. Computerized modeling of the implant was performed for each patient based on ultrasound measurements and optimized prior to ordering the radioactive seeds from the manufacturer. Medical evaluation was performed to insure that there was no risk for general anesthesia.

The day of the procedure, the implanter needles were pre-loaded with the appropriate seeds and spacers based on the pre-operative comput-

er plan. For patients receiving iodine implants, a product containing the seeds enmeshed in strands of absorbable suture were used for the periphery of the implant to minimize subsequent movement in the periprostatic fat.[24] The patient was given a general anesthetic and placed in the extended lithotomy position. Trans-rectal sonography was carried out to insure that the prostate position precisely matched that of the planning study. A grid attached to the ultrasound probe with holes spaced at 5 mm intervals in both the AP and lateral planes was used to place each needle in its proper position. Each needle was placed under ultrasound guidance, and the position of each seed was verified with a C-arm fluoroscopy unit during implantation. Following the implant, cystoscopy was performed to see if any of the seeds had passed into the bladder or the urethra. CT scanning and/or orthogonal x-rays were obtained post-operatively on all patients so that the post-treatment radiation dose distribution could be established and compared to the pre-operative plan as a quality control measure. Patients were discharged home on the afternoon of the procedure. Discharge medications included an antibiotic, an analgesic, and a urinary antispasmodic drug at the discretion of the urologist.[25] Non-diabetic patients were given a short tapering schedule of dexamethasone to help them through the acute phase of prostatic edema resulting from the implant. Diabetic patients were given one of the non-steroidal anti-inflammatory drugs. Most patients went home without a catheter, unless the urologist was concerned about their ability to void based on cystoscopy.[26] PSA follow-up began three months following the implant to allow time for the effects of androgen blockade to wear off. PSA disease-free survival is defined as a stable value less than 1.0.[27] Follow-up biopsies were not routinely performed but were considered in patients with rising PSA.[28]

Results

Median follow-up of our initial 150 patients occurred at three years. Three died of unrelated medical problems, and seven were lost to follow-up, leaving 140 evaluable patients. The average age was 67 (range 42 to 79). Seven patients had biochemical evidence of failure (PSA rising above 1.0) and one of those patients developed bone metastasis, ultimately dying from prostate cancer. Biochemical disease-free survival is therefore 95%. Five of the seven PSA failures were patients that would have been considered "high-risk" by today's standards who had been treated with implant alone (without external beam supplement). If these were excluded from analysis, the PSA disease-free survival for the remaining group of 135 patients treated according to our current protocol would be 99%.

Questionnaires were mailed to all patients addressing quality of life issues. Eighty-eight were returned (63%). When asked if they would recommend brachytherapy to other men with prostate cancer, 98% said that they would. This is considerably higher than other published results and may reflect the active role our patients took in selecting their mode of cancer treatment.[29]

Potency was assessed by asking the general question: "How is your sexual function?" Most respondents elaborated in detail. Many reported a low volume or "dry" ejaculate, though their performance and sensation of orgasm were good. Each response was evaluated as to whether the patient was satisfied with their function. Those who were satisfied were considered potent. Fifty-eight percent of the respondents met this definition of potency. Other published series vary as to the definition of potency, though most consider it to be the ability to obtain an erection sufficient for vaginal penetration.[30] There were respondents in our group who would have met this requirement but who were clearly not satisfied with their function. Other quality-of-life issues pertained to urinary and bowel function as a result of treatment.

Six patients in our series required an indwelling foley catheter for more than two weeks following the implant. Five of these were men whose prostate was greater than 50 cc in volume at the time of implant and, hence, required a large number of radioactive seeds to adequately encompass the gland in the prescribed radiation dose volume. One patient with a smaller gland was noted to have chronic obstructive findings on his post-implant cystoscopy, though he had not related obstructive symptoms in his history. Five of these six men ultimately regained normal urinary function, though three required transurethral incision of the prostate. One required a suprapubic catheter for about one year. Thus, the urinary complication rate is 4%. Our present selection criteria exclude men with glands > 50 cc in volume. If these cases were excluded from our original series, the overall urinary complication rate would be less than 1%. Since we have begun excluding patients with large glands, no one has required long-term catheter placement.

Chronic radiation proctitis is defined as pain, excessive mucous formation, or rectal bleeding occurring more than six months after implant. Eight percent of our patients had chronic radiation proctitis. These men were treated with an intrarectal steroid preparation and Metamucil. All but two patients had complete disappearance of their symptoms with conservative management.

Discussion

The side effects of radiation therapy are the result of normal tissue reaction to the ionizing irradiation. Brachytherapy treatment results in the irradiation of a precisely confined volume of tissue. Nevertheless, the prostatic urethra, bladder neck, and anterior rectal wall are unavoidably included in this volume. These mucosa-lined surfaces are susceptible to radiation effects due to the relatively high turnover rate of lining epithelial cells. Virtually all men will have symptomatic urethritis manifesting as frequency and dysuria for one to two months following the implant. Most men experience a decrease in stream force for a few weeks following the implant as a result of prostatic edema resulting from the physical trauma of implanting the seeds. Ten percent to 15% may experience symptoms of radiation proctitis in the first few months after treatment. Ninety percent of patients will have complete disappearance of these side effects within a few months of the implant. When these symptoms are prolonged or require intervention to control their severity, they are counted as complications of treatment.

Published series report a 19% incidence of rectal bleeding following prostate brachytherapy which virtually always heals spontaneously.[31,32] Heavily irradiated tissues heal slowly and should not be biopsied. An ulceration in the anterior wall of the rectum overlying the prostate in a patient who has undergone brachytherapy is pathoneumonic for radiation effect. Both of our patients who did not heal had endoscopic biopsies of radiation ulcers performed by a gastroenterologist, and both ultimately required a colostomy (neither biopsy showed cancer).

Conclusions

Prostate cancer patients who are appropriate candidates for treatment with brachytherapy should be counseled regarding alternative methods of treatment and the expected side effects of brachytherapy. They should be given time to make an informed decision about their choice of treatment. Proper patient selection is essential to minimize side effects. Patients treated with brachytherapy enjoy a relatively good quality of life and have cure rates comparable to those treated with other modalities. Brachytherapy should continue to be a part of the arsenal of curative treatment modalities for men with localized prostate cancer. JJ

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Improving the Health of Oklahomans Through Clinical Prevention, Part II: Screening to Identify Early-Stage Disease and Risk Factors

James M. Crutcher, MD, MPH; David J. DeRose, MD, MPH; Sara Reed DePersio, MD, MPH

The purpose of screening is to identify asymptomatic disease, or risk factors for disease, so that interventions can occur as early as possible in the disease process. The primary goal is to decrease the morbidity the patient experiences from the disease. For infectious diseases, screening can benefit not only the individual with the disease but also the community, since infectious persons can be identified and treated prior to transmitting the disease to others. Although screening can be very beneficial to the individual and to the community, it can also have adverse outcomes if not used appropriately. In this article we will discuss current recommendations for the use of screening tests and their role in addressing the leading causes of morbidity and mortality in Oklahoma. In general, physicians should consistently screen for the risk factors for cardiovascular disease and stroke (hypertension, high cholesterol, obesity and diabetes) and for early-stage cancers of the colon, breast, and cervix. They should also consider screening Native Americans for diabetes and persons at increased risk for certain infectious diseases, particularly sexually transmitted diseases.

Introduction

This is the second article in a three-part series that explores the relative poor health of Oklahoma residents (as documented in the *State of the State's Health Report*[1]) and the role of clinical prevention in improving that situation. For many of the conditions that cause the greatest amount of illness in our population, prevention is currently the only viable option for decreasing the disease burden. Clinical prevention refers to preventive services provided by physicians or staff in their offices during the routine care of their patients and can be categorized into three general types of services: 1) counseling, 2) screening, and 3) immunizations and chemoprophylaxis. Part I addressed counseling activities and concluded that Oklahoma physicians should consistently deliver messages that address tobacco products, alcohol and other drugs, the use of seat belts, diet and exercise, and that they should recommend that all women of childbearing age who are capable of becoming pregnant take a multivitamin daily containing folic acid for the prevention of neural tube defects.[2] In this article we will discuss the role of screening tests to identify early-stage disease and risk factors so that interventions may take place as early as possible in the disease process. The final article will discuss immunizations and chemoprophylaxis.

The recommendations made here are based in large part upon the findings of the US Preventive Services Task Force (USPSTF). The task of that body was to thoroughly review current preventive medicine research and make recommendations as to which office-based interventions have been clearly shown to decrease morbidity and mortality in asymptomatic Americans. The USPSTF findings were published in *The Guide to Clinical Preventive Services*[3], and later used as the scientific background for the "Put Prevention into Practice" (PPIP) program and its companion book *The Clinician's Handbook of Preventive Services*.[4] Readers should refer to Part I for a review of the history of the USPSTF and other clinical prevention activities in the United States.

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The sources for the Oklahoma-specific data used in this report include the following: 1) Oklahoma Vital Records for mortality data; 2) Oklahoma Central Cancer Registry for cancer incidence data; and 3) the Behavioral Risk Factor Surveillance System (BRFSS), an ongoing telephone survey coordinated by the Centers for Disease Control (CDC), for data on health-related outcomes and behaviors.

The Science of Screening Tests: Which Ones Should Be Used?

Screening tests are special tests or standardized examination procedures for the early detection of preclinical conditions (eg, cervical dysplasia) or risk factors (eg, elevated serum cholesterol or obesity) in *asymptomatic* persons. The *Guide* evaluated screening procedures for 53 different conditions that can be grouped into nine categories: cardiovascular diseases; neoplastic diseases; metabolic, nutritional and environmental disorders; infectious diseases; vision and hearing disorders; prenatal disorders; congenital disorders; musculoskeletal disorders; and mental disorders and substance abuse.

The logic behind the early detection of disease through screening is obvious. It is more rational to screen for and treat asymptomatic persons with high blood pressure than to, years later, manage the consequences of renal failure or stroke. However, screening tests can result in adverse outcomes if not used wisely and must satisfy two major requirements to be considered effective. First, the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false positives and false negatives (accuracy of screening tests). Second, screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared to treating patients when they present with signs or symptoms of the disease (effectiveness of early detection). Failure to meet both of these criteria can result in adverse outcomes from testing procedures. Potential adverse consequences of screening tests include direct physical complications from test procedures, patient labeling based on test results, inappropriate cost to the patient, and utilization of resources needed for other health services. Only a few of the currently available screening tests are sufficiently accurate and effective that they are routinely recommended for use in selected asymptomatic persons. After an extensive and critical review of the literature, USPSTF determined that, although routine screening can lower mortality for selected conditions (eg, breast, cervical, and colon cancer; hypertension) routine screening for most other diseases appears to have little or no effect on health outcomes. The strict application of the above criteria has resulted in some USPSTF recommendations that differ somewhat from previous recommendations of other groups.

Risk Assessment and Focused Screening to Address Major Health Problems Among Oklahomans

The top two causes of mortality among Oklahomans are cardiovascular disease and cancer. And, as described in Part I of the series, Oklahomans suffer higher levels of morbidity and mortality from several health conditions—coronary heart disease, chronic lung disease, stroke, and injury—than the residents of most other states. Used appropriately, selected screening tests can decrease the burden of these diseases among Oklahoma residents.

Central to the theme of prevention is the concept of risk assessment. Although there are many obstacles to the provision of clinical prevention, in many cases the failure to receive preventive care is attributable to the failure of clinicians to include risk assessment in their routine care of asymptomatic and healthy patients. Risk assessment in the clinical setting refers to the collection of information about risk factors during the history, physical, and laboratory examination. Risk factors are personal characteristics, physiological parameters, symptoms, or preclinical disease states that increase the likelihood that an individual has or will develop a particular disease. Risk assessment should not be viewed as a unique clinical activity, separate from routine patient care. Ultimately, high-quality preventive care requires the clinician to adopt a risk factor-oriented thinking process that is independent of the evaluation of current complaints.[5]

Risk assessment is necessary for the effective delivery of all preventive services, including the rational ordering of screening tests. The USPSTF has recommended that physicians avoid routine test batteries and instead order selected screening tests based on the patient's individual risk profile. This recommendation obviously requires the physician to first identify the patient's risk factors. It also reinforces the need for physicians to return to the time-honored tradition of careful history taking and to limit the current over-reliance on laboratory testing.[5]

USPSTF recommendations for the use of screening tests vary depending upon the person's

age, sex, and whether or not certain high-risk behaviors or characteristics are present. The complete list of USPSTF age-specific screening recommendations is shown in Table 1; readers should refer to the *Guide* for a thorough review of all screening interventions. In the remainder of this article we will focus on selected screening activities that, if widely employed by Oklahoma clinicians, can potentially decrease the diseases that are the major causes of morbidity and mortality among Oklahoma residents. Specifically, we will address screening for: 1) risk factors associated with cardiovascular disease and stroke (hypertension, elevated cholesterol, obesity, and diabetes); 2) cancers of the breast, cervix, and colon; and 3) selected infectious diseases, especially those that are sexually or perinatally transmitted.

Table 1. Age-Specific Clinical Screening Recommendations of the US Preventive Services Task Force[2]

Birth to Ten Years

Birth: Hemaglabinapathy – Screening dependent upon prevalence af high-risk individuals in patient papulatian and other cansideratians.

Birth: Phenylalanine – If dane within first 24 haurs af life, repeat by age 2 weeks.

Birth: T4 ar TSH – Optimally between days 2 and 6, but in all cases before newbarn nursery discharge.

Height and weight.

Blaad pressure.

Visian screen (age 3-4 yr.)

Ages 11 to 24 Years

Height and weight.

Blaad pressure.

Papanicalaau test (Pap smear) – Females wha are ar have been sexually active: q ≤ 3 yr. If histary unreliable, begin at 18 yr.

Assess far prablem drinking and illicit drug use.

Chlamydia & ganarrhea (sexually active females <20 yrs.)

Rubella seralogy or vaccinatian hx (females >12 yrs.)

Ages 25 to 64 Years

Height and weight.

Blaad pressure.

Tatal serum chalesteral (males ≥ 35 yr, females ≥ 45 yr).

Papanicalaau test (Pap smear) – females wha have been sexuolly octive and have cervix: q ≤ 3 yr.

Fecal accult blaad test q 1 yr and/ar sigmoidascapy q 5 yr (≥ 50 yr).

Mammagram q 1-2 yr ± clinical breast exam q 1 yr (females ≥ 50 yr).

Assess far prablem drinking and illicit drug use.

Ages 65 and Older

Height and weight.

Blaad pressure.

Fecal accult blaad test q 1 yr and/ar sigmoidascapy q 5 yr.

Mammagram q 1-2 yr ± clinical breast exam q 1 yr (wamen < 70 yr).

Papanicalaau test (Pap smear) – females wha have been sexually active and have cervix: q ≤ 3 yr. If > 65 yrs consider discantinuatian if regular screening has always been narmal.

Visian screening.

Assess far hearing impairment.

Assess far problem drinking and illicit drug use.

Screening for Risk Factors for Coronary Artery Disease and Stroke

Table 2 compares mortality rates from selected cancers and chronic diseases for Oklahoma men and women against US averages. Whereas Oklahomans experience similar mortality rates for the most common cancers, we are significantly higher for several chronic disease conditions, including ischemic heart disease, chronic obstructive pulmonary disease, and stroke. Most notably, the annual death rate for Oklahoma males from coronary heart disease (CHD) substantially exceeds the national rate for men (166 vs 124 per 100,000, respectively); moreover, it rose nearly 14% from 1990 to 1996. The cardiovascular health of Oklahoma females reveals a similar pattern, with a mortality rate of 77/100,000 compared to the national rate for females of 62/100,000.

What role can screening play in decreasing the impact of CHD? USPSTF found no evidence that routine screening for established CHD with such procedures as resting electrocardiograms or stress tests would decrease the morbidity and mortality associated with the disease. They concluded: "The only interventions proven to reduce coronary events in asymptomatic persons are modifications of risk factors such as smoking, high cholesterol, and elevated blood pressure. These interventions, however, should be encouraged for all patients with modifiable risk factors, not only those with screening tests suggestive of CHD." Their recommendations do not exclude screening selected asymptomatic individuals for CHD, such as those with higher risk factor profiles. However, the emphasis is on screening for risk factors. Table 3 shows the prevalence of selected risk factors for CHD and stroke among Oklahoma residents.

Hypertension

The USPTF recommends screening for hypertension in all children and adults. High blood pressure is a well-recognized risk factor for a host of diseases including coronary artery disease, heart failure, stroke, and renal failure. This condition affects millions of Americans and a large percentage of Oklahomans—22% of state BRFSS respondents report that they have been told on at least one occasion that their blood pressure is elevated (Table 3). Fortunately, blood pressure testing is frequently performed—94%

Table 2. Gender-Specific Mortality Rates* for Selected Causes of Death: Oklahoma vs United States, 1994-1996

	Oklahoma men	US Men	Oklahoma women	US wamen
Cancers				
Breast Cancer			22	22
Cervical Cancer			2.8	2.5
Colorectal Cancer	15	22	11	15
Lung Cancer	66	73.5	30	27
Ovarian Cancer			6	7.8
Pancreatic Cancer	7	10	5	7.3
Prostate Cancer	15	26.8		
Skin Cancer	4	2	2	1.5
Other Chronic Diseases				
Chronic Obstructive Pulmonory Disease	33.5	26.3	19.1	17.1
Diobetes	13.0	14.4	12.0	12.4
Ischemic Heort Diseose	166.2	123.9	77.3	61.9
Stroke	32.0	28.9	28.7	24.8

Source: Oklahoma State Department of Health, Chronic Disease Division. Chronic Disease Mortality Information Sheet, 1996.

* Rotes per 100,000 population

Table 3. Race- and Ethnicity-Specific Prevalence of Selected Risk Factors Among Oklahomans

	Total (US Median)	White	African American	Hispanic	Native American
Percent of adults self-reported as obese*	15.1 (16.6)	14.5	16.1	27.7	17.9
Percent of adults told by health professional on at leost one occasion that their BP is elevated	21.8 (23.0)	21.8	28.1	17.3	20.7
Percent of adults told by heolth professional they have diabetes	5.8 (4.8)	5.1	6.7	8.5	13.3
Percent of adults told by heolth professional they have elevated cholesterol	22.1 (28.6)	22.1	16.0	-	28.6
Percent of adults who report no leisure time physical activity in the last 30 days	38.3 (28.0)	37.2	44.8	44.5	43.2

Source: 1997 Oklahoma Behavioral Risk Factor Surveillance System (BRFSS) survey. N = 1881

* Body Moss Index ≥ 30, calculated from self-reported height ond weight

of persons in the United States and Oklahoma report that their blood pressure had been checked within the last 2 years (Table 4). Of concern, however, is that patients often do a poor job of controlling their blood pressure even when they know it is elevated. Data from the National Health and Nutrition Examination Survey III (1991-1994) indicate that while 68.4% of persons with elevated blood pressure were aware of their condition, only 53.6% were under therapy and in only 27.4% was their blood pressure controlled. Clearly, Oklahoma physicians should maintain continued vigilance when it comes to diagnosing and treating hypertension.

Cholesterol

Elevated cholesterol is one of the major modifiable risk factors for CHD. "Borderline high" and "high" cholesterol levels are defined as values of 200-239 mg/dl, and greater than 240 mg/dl, respectively. However, studies of large cohorts followed over extended periods indicate that CHD risk increases in a continuous and graded fashion, beginning with cholesterol levels as low as 150-180 mg/dl.[3] During middle age, for each 1% increase in total cholesterol, CHD risk increases an estimated 3%.[6] Among middle-aged men, 9% to 12% of those with cholesterol 240 mg/dl or greater will develop symptomatic CHD

Table 4. Percentage of Oklahomans Who Have Undergone Recommended Screening Procedures

Screening Procedure	Oklahoma Percentage	National Median	OK State Rank*
Ever had cholesterol checked	77.5%	74.0%	10
Cholesterol checked within the last five years	74.4%	69.1%	8
Blood pressure checked within the last two years	94.2%	94.0%	25
Persons 50 and older who have ever had sigmoidoscopy	22.3%	40.8%	52
Persons 50 and older who have had a home stool blood test within the past two years	14.3%	26%	51
Women 50 and older who have had a mammogram within the past two years	65.2%	73.7%	47**
Women 50 and older who have had a breast exam within the past two years.	81.7%	77.0%	10
Women 18 and older who have had a Pap smear within the past three years.	84.4%	84.7%	29**

Source: 1997 Oklahoma Behavioral Risk Factor Surveillance System (BRFSS) survey. N = 1881

* unless otherwise noted, ranked out of 52 reporting entities (includes all 50 states as well as Puerto Rico and the District of Columbia)
** ranked out of 51 reporting entities (California not included)

Table 5. Classification of Overweight and Obesity by BMI, Waist Circumference, and Associated Disease Risks

	BMI (kg/m2)	Obesity Class	Disease Risk* Relative to Normal Weight and Waist Circumference: Men <40 in. waist Women <35 in. waist	Disease Risk* Relative to Normal Weight and Waist Circumference: Men >40 in. waist Women >35 in. waist
Underweight	<18.5		–	–
Normal+	18.5 -24.9		–	–
Overweight	25.0 - 29.9		Increased	High
Obesity	30.0 - 34.9	I	High	Very High
	35.0 - 39.9	II	Very High	Very High
Extreme Obesity	> =40	III	Extremely High	Extremely High

* Disease risk for type 2 diabetes, hypertension, and CVD.
+ Increased waist circumference can also be a marker for increased risk even in persons of normal weight.

over the next 7 to 9 years.[7,8]

There is now good evidence that cholesterol-lowering interventions can reduce the risk of CHD in persons with high cholesterol. Consequently, USPSTF advocates cholesterol screening for all men aged 35 to 65 and all women 45 to 65. They concluded that there was insufficient evidence to recommend for or against routine screening of asymptomatic persons of other age groups, but that it may be indicated in some individuals with other CHD risk factors. The appropriate interval for periodic screening is not clear based on the current evidence, but an interval of five years has been recommended by experts.[9] Longer intervals may be reasonable in low-risk subjects. Initial therapy for persons found to have high cholesterol levels include counseling to reduce consumption of fat (especially saturated fat) and promotion of exercise and weight loss in overweight persons. Specific cholesterol-lowering diets and drug therapy may be indicated for those who fail to respond to the above, or are at high risk of CHD.

High cholesterol (greater than 240 mg/dl) is prevalent in the United States, ranging from 8% to 9% in adults under age 35, to nearly 25% for men age 55, and nearly 40% for women over 65.[10] In Oklahoma, 22% of BRFSS respondents stated that they have been told by a health professional that they have high cholesterol, with the highest rates occurring in Native Americans (28.6%) (Table 3).

Cholesterol screening appears to be a common practice in the state—almost 75% of

Table 6. Cancer Screening Tests Recommended by the USPSTF

Concer Type	Specific Concer Tests Recommended in Asymptomatic Patients
Breast	Mammagraphy every ane ta twa years for women 50 ta 69 years ald.
Cervical	Pap testing at least every three years of all wamen with a cervix wha are or have ever been sexually active.
Calon	All Americans aver 50 shauld have annual accult stool blaad testing and/ar sigmaidoscapy (aptimal frequency af latter unknawn but every five years generally recammended).

BRFSS respondents stated that their cholesterol had been checked in the last five years (Table 4), but there is still room for improvement. And, as discussed in Part I, clinicians should consistently deliver messages to all patients, including those with normal cholesterol levels, regarding dietary intake of fats and other measures (smoking and exercise) to reduce the risk of CHD.

Diabetes

Patients with diabetes mellitus are at significantly increased risk for CHD, stroke, and peripheral vascular disease, and diabetic nephropathy is now the leading cause of end-stage renal disease in the United States.[11] Approximately 14 million Americans have diabetes, with non-insulin dependent diabetes mellitus (NIDDM) or type 2 diabetes accounting for 90% to 95% of cases and insulin-dependent diabetes mellitus (IDDM) or type 1 diabetes accounting for the remainder.[12] The prevalence of type 2 diabetes steadily increases with age, and it is estimated that nearly 20% of the US population aged 65 to 74 has diabetes.[13] The prevalence of type 2 diabetes is markedly increased in Native Americans and is also higher among African American and Hispanic populations.[14] This makes diabetes a particularly important issue in Oklahoma because of our large Native American population. This increased risk is reflected in our state BRFSS data—although 5.8% of all Oklahoma respondents said they had ever been told by a health professional that they had diabetes (compared to 4.8% nationally), the rates were higher among minority groups, with the highest risk among Native Americans (13.3%) (Table 3).

Although diabetes is a significant risk for CHD and stroke, USPSTF concluded that there was insufficient evidence to recommend for or against routine screening for type 2 diabetes in all adults, but that it is more likely to be beneficial in certain high-risk groups—obese men and women over age 40, patients with a strong family history of diabetes, and members of certain ethnic groups (Native Americans, Hispanics, and African Americans). Measurement of fasting plasma glucose is recommended as the screening test of choice; the frequency of screening is left to clinical discretion.

Primary prevention may be a more effective means to reduce diabetes-related morbidity than widespread screening. Diet, exercise, and weight reduction can safely improve glucose tolerance and are likely to have independent benefits on other important chronic diseases.[15]

Persons with established diabetes should be routinely screened for eye, kidney, and peripheral vascular complications, and should have glycosylated hemoglobin measurements performed at least twice a year. Early detection of diabetic retinopathy through screening and timely intervention with laser photocoagulation can reduce the incidence of severe vision loss by 50% to 90%, and is highly cost-effective.[16]

Obesity

There is clear rationale for including obesity among cardiovascular risk factors. USPSTF notes that observational studies have established an association between overweight and well-established CHD risk factors—hypercholesterolemia, diabetes, and hypertension—and suggest an independent relationship between overweight and CHD. Being overweight also increases the risk for a host of other problems, including cancers of the colon, rectum, prostate, breast, cervix, endometrium, and ovary; cholelithiasis; sleep apnea; venous thromboembolism; and osteoarthritis. A 1998 National Institutes of Health expert panel concluded that obesity is among our nation's most urgent emerging chronic disease risk factors.[17] These findings suggest that excess weight is one of the most prevalent CHD risk factors among Oklahomans, as it is estimated that 30% of the adult population in the state (970,000 persons) are significantly overweight.[18] Furthermore, 15% of Oklahoma BRFSS respondents self-reported themselves as "obese" (Body Mass Index ≥ 30).

Although losing weight in itself has not been proven to reduce morbidity and mortality, USPSTF notes that it is now clear that losing weight reduces a person's risk for major chronic diseases such as hypertension and CHD, and also improves management of hypertension and dia-

betes. In order to identify and monitor this risk factor, USPSTF recommends that all patients be routinely screened for obesity with height and weight measurements. The procedures are inexpensive, rapid, and require minimal training to perform, and may also be useful in detecting medical conditions causing unintended weight loss or gain. Indeed, this is already standard procedure in most primary care practices.

An alternative measure to using height-for-weight tables is the Body Mass Index (BMI), which is calculated by dividing the body weight in kilograms by the square of the height in meters (kg/m^2). (To avoid making the metric conversion, divide patient's weight in pounds by their height in inches squared, then multiply the result by 703). Guidelines for classification of weight status based upon the BMI have recently been published by the National Heart, Lung, and Blood Institute (NHLBI) Obesity Education Initiative Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults (Table 5).[17] Note that they have added waist measurements to their recommended guidelines because of evidence linking abdominal obesity with poorer health outcomes.

All patients identified as overweight should be advised of their condition and given appropriate counseling to promote physical activity and a healthy diet. As discussed in Part I, although physicians may lack the time and skill to provide detailed recommendations concerning diet and exercise, they can at least emphasize the benefits of good nutrition and exercise, and provide written materials and refer those who need more intense counseling to other providers with greater expertise.

Cancer Screening

Cancer is the second-leading cause of death in Oklahoma, causing 22% of all deaths in the state. While the United States as a whole has experienced little change in malignancy death rates over the last 15 years, Oklahoma has seen a small rise in death rates over that same time period. The leading cancer causes of death among Oklahoma men are malignancies of the lung, prostate, and colon; for women, cancers of the lung, breast, and colon are the leading killers (Table 2). Although numerous tests exist that could be used to screen for various malignancies, few meet the requirements for effective screening tests (see section on "The Science of Screening Tests"). In this section we will discuss the three malignancies for which effective screening tests exist and for which USPSTF recommends routine screening for at-risk populations. The current recommendations are summarized in Table 6.

Colon Cancer

Colorectal cancer is a leading cause of cancer morbidity and mortality in the United States, afflicting roughly 140,000 and killing 55,000 Americans each year.[19] The average patient dying of colorectal cancer loses about 13 years of life.[20] Persons at highest risk for colorectal cancer include those with uncommon familial syndromes and those with longstanding ulcerative colitis. Diets high in fat or low in fiber may also increase the risk of colorectal cancer.[21] Fortunately, mortality rates from colorectal cancer for both Oklahoma men (15/100,000) and women (11/100,000) are less than their US counterparts (Table 2). However, there is cause for concern as colorectal cancer mortality for Oklahoma males increased over 30% from 1990 to 1996.

USPSTF found that recent studies have provided compelling evidence that both sigmoidoscopy and the fecal occult blood test (FOBT) are effective in screening for colorectal cancer. For example, studies have documented a 31% to 57% decrease in risk of colon cancer among persons who receive FOBT.[22,23] However, the evidence is not definitive, they concluded, and ongoing studies may further define the role of each of these procedures.

Currently USPSTF recommends periodic sigmoidoscopy and/or FOBT screening for all Americans over 50 years old. They did not find sufficient evidence to recommend one of these methods over the other, or to determine whether the combination of both tests is better than either test alone. Although there is good evidence to support FOBT on an annual basis, there is insufficient evidence to recommend a periodicity for sigmoidoscopy. A frequency of three to five years has been recommended by some experts, but one study indicated that protection remained unchanged when the test was performed as infrequently as every ten years.[24] The appropriate age to discontinue screening has not been determined. More intensive screening is recommended for persons at increased risk for colorectal cancer, although the nature and frequency differs slightly among authorities.

USPSTF guidelines for colorectal cancer screening differ somewhat from other groups, such as the American Cancer Society and the American Gastroenterological Association, which recommend to start screening normal risk

persons at age 50 with *both* FOBT (every year) and flexible sigmoidoscopy (every five years); other options include colonoscopy every ten years or double contrast barium enema every five to ten years. Although the science of colorectal cancer screening continues to evolve, all authorities agree that routine screening of normal risk patients should begin at age 50 with FOBT and/or sigmoidoscopy. Which tests are employed will depend upon factors such as the availability of procedures, resources, and patient preference.

Are Oklahomans being routinely screened for colorectal cancer? State BRFSS data (Table 4) indicates that only 14.3% of respondents over the age of 50 said they had performed a home FOBT in the last two years (we do not have data to indicate how often FOBT is performed in clinical settings), and only 22% said they had ever had a sigmoidoscopy. In both categories Oklahoma ranks close to the bottom when compared to other states. Although our state colorectal cancer mortality rate is lower than the US rate, it would appear that we have significant room for improvement in our screening efforts, which could possibly further decrease the mortality from this disease.

Breast Cancer

Breast cancer is the most common type of cancer in women and the second-leading cause of cancer death in US women after lung cancer. It is estimated that about 180,000 new cases of breast cancer and 45,000 related deaths occur each year in the United States.[3,4] The mortality rate from breast cancer has been relatively stable from 1930 to present,[19] and women have an estimated lifetime risk of dying from breast cancer of 3.6%.[20] The annual mortality rate for breast cancer in Oklahoma women is 22/100,000, equal to the rate for the United States as a whole (Table 2). The strongest risk factor for breast cancer is age—48% of new cases occur in women age 65 and over.[20] The next strongest factor is a family history of breast cancer in a first-degree relative, which increases the risk two- to threefold.[25]

Mortality from breast cancer is strongly influenced by stage at detection; mammography is the most effective method of early detection, with a sensitivity of 70% to 90% and a specificity of 90% to 95%.[26] There is little doubt that mammography, with or without clinical breast exam (CBE), has the potential of reducing mortality from breast cancer for women aged 50 through about 70.[27] Therefore, USPSTF strongly recommends routine breast screening every one to two years for women 50 to 69 years old. They concluded that mammography was the essential part of the screening and that there was insufficient evidence to recommend annual CBE alone or in combination with mammography. Screening women 50 to 69 years old can reduce breast cancer mortality by 20% to 30%.[28] Although mammography can detect small tumors in women of other ages, controversy exists as to whether routine screening reduces mortality in women outside of 50 to 69 years of age. USPSTF recommended that decisions about screening women aged 40 to 49 and those age greater than 70 be made on an individual basis, depending the presence of risk factors, general health, and personal preference of the patient.

Looking again at our BRFSS data, we see that Oklahoma ranks high in the percentage of women over age 50 who have been screened for breast cancer with CBE, but close to the bottom for screening by mammography (Table 4). Although 86% of respondents said they had received a CBE in the last two years, only 65% had received a mammogram in the last two years. Mammography is the most effective method to screen for breast cancer and Oklahoma physicians should not assume that CBE alone is sufficient.

Cervical Cancer

It is estimated that each year about 16,000 new cases of cervical cancer occur in the United States, and that 4,800 women die from the disease.[19] Based upon data from the Oklahoma Cancer Registry it is estimated that 300 Oklahoma women will be diagnosed with cervical cancer in 2000 and that 65 women will die from the disease. The disease is more common in poor women, those with a history of multiple sexual partners or early onset of sexual intercourse, and smokers. In Oklahoma for the period 1994 to 1998, the age-adjusted mortality rates were higher for Native Americans (2.7/100,000) and African Americans (2.3/100,000) than for whites (1.4/100,000). Older women are also at increased risk of dying from cervical cancer; in 1998 the average age of death in Oklahoma from cervical cancer was 56.

The principal screening test for cervical cancer is the Pap smear. When performed and interpreted properly, the test is highly effective at detecting localized cervical cancer, which greatly improves the survival rate. USPSTF recommends routine Pap screening for all women who are or have been sexually active and who have a

cervix. Pap smears should begin with the onset of sexual activity and should be repeated at least every three years. Although annual testing has been the common practice in the United States, USPSTF found that screening women aged 20 to 64 every three years reduced the cumulative incidence of invasive cancer by 91%, while screening annually reduced the incidence by 93%. They concluded that the significantly greater expenditure of resources required to perform the test every year instead of every three years provided only limited added benefit in lowering mortality, and that the effectiveness of screening is more likely to be improved by extending testing to women who are not currently being screened than by efforts to increase the frequency of testing. The task force found insufficient evidence to recommend an upper age limit for Pap testing but concluded that it may be reasonable to discontinue testing at 65 in women who have had regular follow-up and consistently normal Pap smears. However, it may be necessary to continue testing past 65 in those groups of women who are not likely to have had regular screening, such as poor and minority women.

BRFSS data indicate that 84% of Oklahoma women age 18 and older stated that they had received a Pap smear in the last three years, which is about average for the United States. Younger women (ages 18 to 29) and older women (65 and older) as well as Hispanic and African-American women were the groups most likely to never have had a Pap smear.

Mortality from cervical cancer is almost totally preventable through the appropriate use of Pap testing and Oklahoma physicians should strive to provide it to every woman for whom it is recommended. Physicians should be particularly mindful of new patients who are not likely to have had access to health services, as these women have been shown to be at increased risk of cervical cancer.[29]

Routine Screening Not Recommended for Other Cancers

The above three malignancies are the only ones for which USPSTF found sufficient evidence to recommend routine screening of asymptomatic persons. In the opinion of USPSTF, the screening tests for the other cancers did not meet the previously described requirements for effectiveness—adequate sensitivity and specificity and the ability to improve outcomes compared to treating patients when they present with signs and symptoms of disease.

The most controversial of these "non-recommendations" pertains to prostate cancer. Many authorities currently recommend an annual digital rectal exam (DRE) and Prostate-Specific Antigen (PSA) testing beginning at age 50. Although these tests may detect clinically important cancers at an early stage, they are also likely to detect a large number of cancers of uncertain significance, leading to unnecessary procedures and potential complications in a large number of men. Furthermore, USPSTF concluded that there is no evidence to determine whether or not early detection and treatment improve survival. They recommended that if patients are to undergo screening, they should be given objective information about the potential benefits and harms of early detection. Although such counseling is proper for all forms of screening, it is especially important for prostate cancer because of current uncertainty about effectiveness. If screening is to be performed, the best-evaluated approach is to screen with DRE and PSA, and to limit screening to men with a life expectancy of greater than ten years and to those who are willing to accept the risks of incontinence, impotence, and other treatment complications.[3]

Screening for Infectious Diseases

Screening at-risk persons for certain infectious diseases may be indicated for two general reasons: 1) screening may identify asymptomatic persons who would benefit from therapy prior to the onset of more serious disease, eg, chlamydia and TB; and 2) screening may identify infectious persons so that steps can be taken to prevent transmission to others, through either treatment or behavior modification of the case-patient, or vaccination/prophylaxis of contacts, eg, HIV and hepatitis B. Of course, there is overlap in these two areas since any intervention that eradicates an infection in an individual also decreases the likelihood of transmission to others in the community. Particular emphasis is given to screening for diseases in pregnant women to prevent infections of newborns. In this section we briefly review the USPSTF recommendations for screening for infectious diseases.

HIV and Other Sexually Transmitted Diseases (STDs)

STDs (chlamydia and gonorrhea) are the most commonly reported diseases in Oklahoma, and the state has higher rates for a number of STDs than the US average. Moreover, a recent increase in syphilis cases has resulted in Oklahoma County ranking among the top twenty counties in the

United States for syphilis rates.[30] Although STDs are common in Oklahoma, BRFSS data indicate that only about 10% of men and 20% of women in our state ever recall a health professional asking them questions about sexual history.

Through 1999, almost 5,600 cases of HIV disease (AIDS and HIV) have been reported in Oklahoma since the disease became reportable in 1983. Over the period 1995 to 1999, an average of 550 new HIV cases have been reported each year. The vast majority of cases are male (88%), and African Americans have a three to five times higher rate of disease than whites and Native Americans. The most common risk factor for HIV infection in Oklahoma is men who have sex with men (55% to 60% of cases), followed by injection drug use (12% of cases).

Detection of asymptomatic HIV infection permits early treatment to slow disease progression, interventions to reduce perinatal transmission, and counseling to prevent transmission of virus to uninfected sex partners or persons sharing injection needles. USPSTF recommends that clinicians assess risk factors for HIV infection in all patients by taking a careful sexual history and inquiring about drug use. Counseling and testing for HIV should be offered to all persons at increased risk for infection. Screening is recommended for all pregnant women at risk for HIV infection and for infants born to high-risk mothers if the mother's antibody status is unknown.

Chlamydia trachomatis is the most commonly reported infectious disease in Oklahoma, with almost 9,000 cases reported annually. Chlamydial infections are responsible for 25% to 50% of cases of pelvic inflammatory disease (PID), which is an important cause of infertility and ectopic pregnancy. Because of the potential for significant morbidity in women and the fact that up to 70% of women with chlamydial infection are asymptomatic, routine screening during pelvic examination is recommended for all sexually active female adolescents and other women at high risk for chlamydial infection. Higher-risk persons include those with a history of prior STD, new or multiple sex partners, age under 25, inconsistent use of barrier contraceptives, cervical ectopy, and being unmarried. Pregnant women at high risk should also be tested. Gonorrhea is also common in Oklahoma, with an average of 6,000 cases reported annually from 1995 to 1999, and the same screening recommendations as for chlamydia apply to gonorrhea. Routine serologic testing for syphilis is recommended for all pregnant women and for persons at increased risk for infection.

Hepatitis B

An estimated 22,000 births occur to hepatitis B (HBV)-infected women each year in the United States,[31] with 80 to 120 occurring in Oklahoma. These infants are at high risk of becoming chronically infected with HBV, which increases their risk of developing cirrhosis and cancer of the liver. Hepatitis B vaccine, in combination with a single dose of hepatitis B immune globulin (HBIG) given within 12 hours of birth, is 75% to 95% effective in preventing chronic infection. Because of the potential severe consequences of perinatal HBV transmission and the availability of an effective therapy, routine screening with hepatitis B surface antigen (HbsAg) is recommended for all pregnant women at their first prenatal visit. The test may be repeated in the third trimester for women who are initially negative and are at increased risk for HBV infection during pregnancy. Hepatitis B vaccine and HBIG are available through the Health Department for all infants born to all HBV-infected women, and all such women should be reported to the Immunization Division of the Oklahoma State Department of Health (405/271-4073).

Conclusions

Progress in medicine can be viewed as an ongoing attempt to intervene in disease processes at earlier and earlier points. In general, the sooner we stop a pathological process, the better the outcome for the patient. Indeed, we have progressed from detecting disease at the point when it causes functional or anatomic abnormalities, to today recognizing pathology at the cellular, molecular, and even behavioral level. The modalities of risk assessment and selected screening for early stage disease (and risk factors for disease) are two modern-day clinical tools that allow us to make the most effective use of early intervention efforts to improve the health of our patients.

Recent prevention research has shown that selected screening tests, used appropriately, can impact the diseases that are the major causes of morbidity and mortality among Oklahoma residents, including CHD, stroke, and malignancies. The recommendations made in this report are based primarily upon the findings of the US Preventive Services Task Force, the most authoritative body in the United States concerning clinical prevention efforts, and can be summarized as follows:

- ***Hypertension:*** All children and adults should be routinely screened.

- ***Cholesterol:*** All men aged 35 to 65 and women aged 45 to 65 should be screened. If normal, an interval of five years is generally recommended but may be longer for low-risk subjects. In Oklahoma, Native Americans are at increased risk for high cholesterol.
- ***Obesity:*** All patients should be routinely screened with height and weight measurements, or with Body Mass Index.
- ***Diabetes:*** Routine screening of the general population is not recommended, but clinicians may decide to screen persons at increased risk. Native Americans have the highest rate of diabetes in the state.
- ***Colorectal cancer:*** All persons over the age of 50 should be routinely screened with annual FOBT, or sigmoidoscopy every five to ten years, or both.
- ***Breast cancer:*** All women aged 50 to 69 should be screened every one to two years, with mammography alone, or with mammography and CBE. CBE alone is not adequate.
- ***Cervical cancer:*** Pap testing is recommended for all women who have ever been sexually active and who have a cervix. Testing should be performed at least every three years.
- ***HIV:*** All persons at increased risk for infection should be counseled and tested.
- ***Chlamydia and gonorrhea:*** All sexually active female adolescents, and other women at high risk, should be tested.
- ***Hepatitis B:*** All pregnant women should be tested at their first prenatal visit.

Although the above screening tests have been shown to have a positive impact on health outcomes, others have not. In addition to making recommendations about which preventive interventions work and how they can be used most effectively, an important function of USPSTF is to determine which ones are not doing what they are supposed to do. This is important because all testing has a cost and puts patients at some risk. Doing something that doesn't work not only places patients at unnecessary risk, but also is not a good use of limited time and resources. For many procedures there is clear evidence as to what works and what doesn't; for others the evidence is not as clear and further research is needed. Physicians should have an understanding of the criteria used to evaluate screening tests (sensitivity, specificity, effectiveness) so that they can choose the test that is most appropriate for an individual patient, and correctly interpret the results. J

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Diabetes: Personal Health Issue and Public Health Problem

Diabetes is the seventh leading cause of death in the United States, contributing to more than 193,000 deaths each year. Currently, an estimated 10.3 million people in the United States have been diagnosed with diabetes—a sixfold increase over the past four decades—and another 5.4 million people have undiagnosed diabetes.

What is diabetes?



Most of the food we eat is turned into glucose, or sugar, for our bodies to use for energy. The pancreas, an organ that lies near the stomach, secretes a hormone called insulin to help glucose get into the cells of our bodies and be converted to energy. Insulin is also needed to synthesize protein and store fats. When you have diabetes, your body either doesn't make enough insulin or can't use its own insulin as well as it should. This causes sugars to build up in your blood and, if uncontrolled, can cause damage to vital organs over time and contribute to heart disease.

What are the symptoms of diabetes?

People who think they might have diabetes must visit a physician for diagnosis. Diabetics may have some—or even none—of the following symptoms:

- Frequent urination;
- Excessive thirst;
- Unexplained weight loss;
- Extreme hunger;
- Sudden vision changes;
- Tingling or numbness in hands or feet;
- Feeling very tired much of the time;
- Very dry skin;
- Sores that are slow to heal;
- More infections than usual.

Nausea, vomiting, or stomach pains may accompany some of these symptoms in the abrupt onset of insulin-dependent diabetes, now called type 1 diabetes.

What are some of the complications of diabetes?

People who have diabetes are at increased risk for serious health complications, including:

- Blindness—diabetes is the leading cause of new cases of blindness in adults aged 20-74 years.
- Kidney failure—diabetes is the leading cause of end-stage (chronic, irreversible) kidney disease.
- Amputations—diabetes is the leading cause of lower-extremity amputations not related to injury.
- Cardiovascular disease—people with diabetes are two to four times more likely to develop heart disease or stroke than people without diabetes.



Diabetes and its complications occur among Americans of all ages and racial and ethnic groups. The burden of this disease is heavier among elderly Americans—more than 18% of adults over age 65 have diabetes—and certain racial and ethnic populations, including African Americans, Hispanics/Latinos, and American Indians and Alaska Natives. Several studies have also shown increased rates among certain Asian and Pacific Islander populations.

Patient Handout #8

What are the different types of diabetes?

Type 1 diabetes was previously called insulin-dependent diabetes mellitus (IDDM) or juvenile-onset diabetes. Type 1 diabetes may account for 5% to 10% of all diagnosed cases of diabetes. Risk factors are less well defined for type 1 diabetes than for type 2 diabetes, but autoimmune, genetic, and environmental factors are involved in the development of this type of diabetes.

Type 2 diabetes was previously called non-insulin-dependent diabetes mellitus (NIDDM) or adult-onset diabetes. Type 2 diabetes may account for about 90% to 95% of all diagnosed cases of diabetes. Risk factors for type 2 diabetes include older age, obesity, family history of diabetes, prior history of gestational diabetes, impaired glucose tolerance, physical inactivity, and race/ethnicity. African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Pacific Islanders are at particularly high risk for type 2 diabetes.

Gestational diabetes develops in 2% to 5% of all pregnancies but usually disappears when a pregnancy is over. Gestational diabetes occurs more frequently in African Americans, Hispanic/Latino Americans, American Indians, and people with a family history of diabetes than in other groups. Obesity is also associated with higher risk. Women who have had gestational diabetes are at increased risk for later developing type 2 diabetes. In some studies, nearly 40% of women with a history of gestational diabetes developed diabetes in the future.

Other specific types of diabetes result from specific genetic syndromes, surgery, drugs, malnutrition, infections, and other illnesses. Such types of diabetes may account for 1% to 2% of all diagnosed cases of diabetes.

What is the treatment for diabetes?

Strategies for managing and treating diabetes should be planned and developed by your doctor. Treatment of diabetes is aimed at keeping blood glucose near normal levels at all times. People with diabetes must learn to manage their blood glucose themselves by addressing medical, psychosocial, and lifestyle issues. Type 1 diabetes typically requires a strict regimen including a carefully calculated diet, planned physical activity, home blood glucose testing several times a day, and multiple daily insulin injections. Type 2 diabetes typically requires diet control, exercise, home blood glucose testing, and in some cases, oral medication and/or insulin.



Can diabetes be prevented?

A number of studies have shown that regular physical activity can significantly reduce the risk of developing type 2 diabetes, which also appears to be associated with obesity. Researchers are looking for both the genetic factors that predispose some individuals to develop type 1 diabetes as well as cures for those with both type 1 and type 2 diabetes. At this time, no know cure has been identified, although researchers are pursuing several different approaches, including transplantation and genetic manipulation.

Source: Diabetes Public Health Resource of the National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Available at: www.cdc.gov/diabetes. Images © 1999-2000 www.arttoday.com.

"Those who suffer losses due to diabetes are not just statistics on a chart. They are people whose talents and wisdom are needed and whose problems deserve our unified efforts. Together we can join to make life more just and more joyful for generations to come."

—David Satcher, MD, PhD,
Assistant Secretary for Health and US Surgeon General

Patient Handout #8

The Nodule

Raymond J. Dougherty, MD

"Sorry," he said. The radiologist for the insurance company reported a nodule in the right upper lung zone, probably a cancer.

Mental depression almost overwhelmed me, but I was not greatly surprised. I had continued to smoke cigarettes for years after it was an accepted fact that they were a major cause of lung cancer. I had finally quit ten years before, but obviously not soon enough. I had played a dangerous game and probably lost.

The x-ray technician had been given permission to have Thanksgiving dinner with his family, obliged to return to the hospital only for emergencies. This was an emergency only for me. It was a time of thanksgiving for him, and a time of fear for me. He was a healthy man who had never smoked cigarettes.

I did not mind the wait; it delayed the inevitable. I needed time to think, time to accept the news that would likely be unfavorable. Lung cancer is an ugly diagnosis. By the time it is seen on x-ray, it has already been present for several years, lying quietly and sending its tiny malignant cells to other organs of the body, especially the brain, liver, and bones, where they lie dormant until it is their time to kill. Ironically, I felt a great need for a cigarette.

Why had I started smoking cigarettes and why had I continued? Reflecting on this brought memories of myself at ten years old, standing on the sidewalk of a small western town with giant dandelions growing between the cracks, a worn-out shirt, overalls, and farm shoes, freckled face and uncombed hair. I was tired of the hot sun and the dust that swirled about the street. It hadn't rained for months. I waited endlessly for my father. He was tall and towered over a small circle of men. He was the only one not smoking a cigarette. He was telling a story and the others were laughing. The story was interrupted when out of nowhere came a new Ford coupe with a nattily dressed young man sitting in the rumble seat. He was laughing as he scattered Lucky Strike cigarettes in the dirty street. The men in the circle stopped laughing and rushed into the street, picking up the cigarettes, dusting them off and placing them in their shirt pockets. These tailor-made cigarettes obviously brought such great pleasure to these hard-working men that they would grovel in the street for them. They usually had to laboriously roll their own with tobacco shaken from a cloth bag into a paper with a glued edge, fighting the wind as they twisted the end and finally lighted up for only a few puffs of smoke. Many farmers stopped their horses at the end of every row to roll one and light up. They coughed a lot.

My uncle was smoking mentholated cigarettes because he was gassed in World War I, and the cigarettes helped him to bring up his phlegm and to forget the horror of the war. On the way to get the cows, my cousin would stop at a hollow log, retrieve his sack of Bull Durham and some cigarette papers, finally succeeding in rolling a cigarette, smiling through watery eyes and coughing. He was my father's favorite nephew.

On our high school senior trip to New Orleans, I watched a beautiful dark-skinned woman and a handsome man smoke cigarettes under an historic oak tree covered with Spanish moss. It was a romantic scene.

At college, members of the student council would stand around with members of the faculty, visiting easily and laughing heartily while leaning against the pillars of the administration building. They held cigarettes delicately between

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the second and third fingers, inhaled the smoke deeply, and then slowly exhaled—none coughed. A small, short-statured student blew perfect smoke rings.

When I began rooming with my cousin, he had changed from Bull Durham to Chesterfields. I sneaked one once in a while, and flushed the evidence in the toilet. Finally, I could smoke one without being lightheaded and nauseous. I didn't give up easily.

A part-time job at the drug store provided low salary, but free cigarettes and ice cream. After a few months of smoking, I noticed that my fingers would turn as white as the vanilla ice cream that I was dipping. This resulted in severe pain, which continued as the fingers turned to bright red and then back to normal. Curiously, sometimes only one or two fingers would be affected, and all of my toes or the toes on only one foot. I was soon being affected by cold water and cold weather. I already suspected that cigarettes were the cause.

An elderly physician recommended by my mother put his pipe in a pipe rack on the top of his mahogany desk. He slowly turned in a swivel chair, took a heavy medical book from a shelf, and showed me a picture captioned "Raynaud's Disease." The hands and fingers were badly deformed and ulcerated. He was as casual as if he was showing a picture of a rare animal. He returned to his desk, selected a beautifully carved pipe, carefully filled it with aromatic tobacco, and smoked slowly with great pleasure. He appeared to be a very learned and wise doctor. He said the cause of the disease was unknown. Good. It seems to be more common in the female. Hell. Worse in those who are anxious. Good. Worse in those who smoked cigarettes. Hell. He glanced uncomfortably at me and my mother and expressed his confidence that cigarette smoking was not the reason in my case. I moved my head in sort of a semi-circle between yes and no. He re-lit his pipe.

He prescribed a crude adrenal extract that I injected into my upper thighs twice a week. The medicine burned like fire and made me nauseous and diaphoretic. Each injection was followed by a red wheel around the injection site, and each was worse than the one before. I consulted with my mother, and we decided that the treatment was worse than the disease. Neither of my parents ever mentioned cigarette smoking to me. Probably wise. Of course, they smelled the tobacco. I always sneaked off to the car shed when I was home, occasionally crossing paths with one of my uncles going to the shed for a nip.

I was in pharmacy school trying to get into medical school. Those hands in the picture the doctor showed me didn't look like the hands of a physician. I enjoyed smoking cigarettes: the aroma and the feel of a cigarette between my fingers. They allayed my hunger, helped me to keep awake at night to study, helped to start a conversation. They made me more comfortable with the girls and lessened my anxiety when taking a test. Most of all, they made me feel more mature and independent. I knew I needed to stop smoking entirely, but noted that the habit was associated with nearly everything I did in my life—getting up in the morning, shaving, talking on the telephone, having a Coke, strolling in the park. If I stopped, I would need more money for food, be more anxious and depressed, less pleasant and humorous. It might spoil my chances for getting into medical school. I might be less attractive to a certain girl that I liked very much.

The best option, I decided, was to decrease the number of cigarettes. This option I tried many thousands of times. It never helped, for the more I tried to reduce the cigarettes, the more I smoked. They did get me through pharmacy school with satisfactory grades and credits for medical school.

After some masterful manipulations of the greatest military force on earth, I found myself filling out a questionnaire for temporary duty in the Army preceding medical school, to which I had not yet been admitted. Being admitted to this program, besides keeping me out of the Army later on, would mean that the Army would pay for medical school. Having come from a family with 11 children and no money, it was probably the only way I could attend. On the questionnaire there was a statement in bold print to the effect that any misstatement regarding past illness or present health that might interfere with duty in the armed forces would result in dishonorable discharge and punishment—possibly death by a firing squad. It was a little difficult to rationalize, given the Raynaud's disease, but I signed the statement that swore to my good health—a deed that was to haunt me during the remainder of my military career.

The building for the follow-up medical examination was large, breezy, and ice-cold. A sergeant with an unusually red face ordered us to strip off our clothes. My hands were as white as the medical form that I was holding. We stood for about three hours in long lines as elderly physicians checked our hearts and hemorrhoids, spending most of the time on the hem-

orrhoids. By this time, the distal two-thirds of my hands and feet, and all of my fingers and toes, were dead white, ice-cold, and unbelievably painful. Luckily, no examiner noticed.

During the next three weeks in abbreviated basic training, I alternated guard duty at night, with frozen toes and fingers, with wonderful, warm KP during the day.

Eventually I was in medical school, courtesy of the United States Army, smoking more than ever to stay awake at night and to calm down during examinations. I stood formations and marched on wooden feet in the winter. I traded the pain for the cigarettes.

After about two years in medical school, the Army decided to reexamine the students for fitness in combat. One had to be there to appreciate the panic. Some students were fat, hypertensive, partially blind, and deaf. Some were nearly flat-footed, with deformed knees, hips, and varicose veins. Again, the examinations were done in a large, cold building, and again we were stripped for the ordeal. Suddenly my fingers and toes turned white, which was the way they stayed during the entire examination. Again, I swore I had no disease or condition that would preclude combat in the Alps. A young internist came along the line and appeared fascinated with my fingers and toes. He called over a couple of other doctors, and they looked and touched as I held my breath; after a period, one asked if I ever had any problems with my hands or feet. "No," I lied. After awhile they walked away, thinking about a picture of a rare disease that they had seen in a book somewhere. St. Jude—the patron saint of the impossible—had prevailed.

I practiced medicine for the next 20 years in warm houses and offices, wearing warm gloves and socks. No patient ever noted the Raynaud's. I smoked in the waiting rooms, examination rooms, laboratories, and consultation rooms, sometimes having more than one cigarette lit at a time. Sometimes I smoked alone, sometimes with the patients. I smoked at breakfast, lunch, and dinner, and with friends in the evening. This continued until I came to hate the smell and taste of nicotine, the dull headaches during an evening out, and the insomnia at night. I was hardly aware that I developed more and more frequent colds and sinusitis with productive coughs that lasted longer and longer, until I was coughing every day. I was aware of constant fatigue and listlessness that I attributed to hard work and pressure from my practice.

Though I was not a big fan of *Reader's Digest*, I kept it in the waiting room of my office, and, one day, a lead article somehow caught my eye. The article described in considerable detail a method for stopping smoking cigarettes. It said that an absolute commitment had to be made to never again smoke a single cigarette. It advised several days of preparation to force the consideration of the problem. An important step was to advertise this plan to as many friends and acquaintances as possible during the several days of preparation. Then, the person was to pick a specific time and date without any cigarettes available. He was to note that the intense desire for a cigarette lasted only 20 to 30 seconds. Those who didn't light up would find that the interval between these intense needs would gradually lengthen and become less intense. But the article warned of compliance, as this desire could be expected to last for a lifetime. It also warned that, if one succumbed and smoked a single cigarette, the painful process would need to be repeated, and each time would be more difficult than the last. The article said that a weight gain was likely, if one was not careful, because of the improvement in taste, smell, and savoring food. It suggested a large glass of water to combat the hunger.

It was Ash Wednesday of 1966. No better day to start thinking about the commitment, then commit to stop on Sunday morning. Suddenly I realized that the commitment was the key. I would not delay another minute. I made the commitment immediately, have not smoked a cigarette since, and never will.

Almost immediately I began to feel better. The Raynaud's disease progressively improved. I gradually stopped coughing and could walk without shortness of breath. I stopped wheezing at night. I awakened refreshed. A renewed sense of purpose and ambition enabled me to finish my medical residency and pass my boards in pulmonary disease. I loved to practice medicine and loved my patients.

The chest x-ray with the cancer-like nodule was my first in several years. The technician was apologetic for keeping me waiting. No, I hadn't been bored. "I guess you knew that you had an azygos lobe."

As a matter of fact, I said, I had completely forgotten.

The Author

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RESOLUTIONS OF THE 2000 OSMA ANNUAL MEETING

(NOT ADOPTED)

Resolution 1: De-unification from the AMA

(A-2000)

Introduced by: Tulsa County Medical Society

Referred to: Reference Committee I

Whereas, In keeping with the tradition of individual choice and the expressed wishes of a majority of Tulsa County Medical Society members, and

Whereas, In order for physicians to maintain an influential position in national health care policy deliberations it is important that they support their national associations including either the American Medical Association or the American Osteopathic Association, now therefore be it

RESOLVED, That while encouraging all members of the Oklahoma State Medical Association to belong to their national associations including the American Medical Association or American Osteopathic Association, membership in these organizations should not be a prerequisite or requirement for membership in their county medical society or the Oklahoma State Medical Association.

(NOT ADOPTED)

Resolution 2: Deletion of AMA Membership Requirement

(A-2000)

Introduced by: Oklahoma County Medical Society

Referred to: Reference Committee I

Whereas, The purposes of the Oklahoma County Medical Society are (1) to promote the art and science of medicine and the betterment of public health and (2) to unite with other county medical societies in the state of Oklahoma to compose the Oklahoma State Medical Association;

Whereas, The Oklahoma County Medical Society is a component society of the Oklahoma State Medical Association and has a long tradition of service in the best interests of its community and physician members;

Whereas, The Oklahoma State Medical Association requires all members of component societies to belong to the Oklahoma State Medical Association and the American Medical Association;

Whereas, The practice of medicine has undergone great change and organized medicine should examine these trends and alter its organizational structure according to the wishes of its members;

Whereas, The Oklahoma County Board of Directors recognizes these changes and desires to offer membership choice to physicians; therefore be it

RESOLVED, That the Oklahoma State Medical Association Board of Trustees offer the option of choice by amending its Constitution & Bylaws to delete the American Medical Association membership requirement; and be it further

RESOLVED, That this request be referred to the Constitution and Bylaws Committee for review and rewrite of the portions of the Constitution and Bylaws pertaining to the AMA Membership requirement; and be it further

RESOLVED, That a proposed amendment providing for de-unification from the American Medical Association be presented to the House of Delegates for discussion and a vote at the 2000 Oklahoma State Medical Association Annual Meeting.

(NOT ADOPTED)

Resolution 3: Proposed Dues Increase for the Oklahoma State Medical Association

(A-2000)

Introduced by: Tulsa County Medical Society

Referred to: Reference Committee I

Whereas, Justification for a proposed 33% membership dues increase by the Oklahoma State Medical Association focuses on financial need and/or the need to provide members services, and

Whereas, The OSMA Treasurer's report at the Annual Meeting in 1999 indicated that "OSMA is in excellent financial condition" and "due to the financially sound condition of the Association…the need of a dues increase is not presently indicated," and

Whereas, The number of staff positions at the OSMA continues to increase to a current total of 16 full-time employees and 5 contract employees, and

Whereas, Many of the services currently provided or planned by OSMA are already provided by county medical societies, now therefore be it

RESOLVED, That any proposal for a membership dues increase by the Oklahoma State Medical Association be returned to the Board of Trustees for further study and not be implemented during the 2000 Annual Meeting of the OSMA House of Delegates.

(NOT ADOPTED)

Resolution 4: Oklahoma State Medical Association (OSMA) Balanced Budget

(A-2000)

Introduced by: Oklahoma County Medical Society

Referred to: Reference Committee I

Whereas, Non-profit organizations tend to operate within a tightly controlled budget, and

Whereas, An increase in membership during past years allowed an increase in dues revenues, and

Whereas, Other non-dues revenues have also increased, therefore be it

RESOLVED, That the Oklahoma State Medical Association require a balanced budget for the year 2000, and subsequent years, in which expenses cannot exceed the revenues derived from combined sources such as dues income, dues commissions, investment income, and miscellaneous income, and be it further

RESOLVED, That a deficit budget, in which expenses exceed revenues not be presented to the House of Delegates for a vote.

(CONSENT CALENDAR)

Resolution 5: Water Fluoridation

(A-2000)

Introduced by: Council on Public and Mental Health

Referred to: Reference Committee II

Whereas, Water fluoridation has been proven safe and effective in reducing dental caries and is considered one of the top ten public health achievements of the 20th century, and

Whereas, Water fluoridation benefits both children and adults and is one of the most cost-effective public health preventive measures available, and

Whereas, State and national medical, dental, and public health organizations have endorsed and recommended water fluoridation, therefore be it

RESOLVED, That the Oklahoma State Medical Association reaffirms its support for water fluoridation and recommends:

1. That all public water systems in Oklahoma be optimally fluoridated to provide this cost-effective oral disease prevention measure to residents throughout Oklahoma, and

2. That member physicians and medical societies work with the state health department and local health departments, dental societies, and concerned citizens to assure that optimal fluoridation of community drinking water systems is achieved.

(ADOPTED AS AMENDED)

Resolution 6: Continuation of Available, Safe Blood Products for State Citizens

(A-2000)

Introduced by: Oklahoma County Medical Society

Referred to: Reference Committee II

Whereas, The quality, safety and availability of blood to citizens of the state of Oklahoma should not be jeopardized due to monetary considerations or constraints related to reimbursement to blood providers, and

Whereas, The Oklahoma Blood Institute, through its mission and dedication, has subsidized operational costs to improve safety and quality and maintain availability, therefore, be it

RESOLVED, That the physicians of the Oklahoma State Medical Association (OSMA) support increased reimbursement to blood centers through third parties to ensure the quality, safety and availability of blood products for the people in the state of Oklahoma. Further, physicians of the OSMA also encourage blood donations and the assistance of community organizations in providing grants/endowments to help support the continuing mission of community blood centers~~, such as the Oklahoma Blood Institute~~ *operating within the state of Oklahoma.*

(CONSENT CALENDAR)

Resolution 7: Silent Preferred Provider Organization (PPO)

(A-2000)

Introduced by: Council on Medical Services

Referred to: Reference Committee III

Whereas, Physicians are patient advocates in the areas of prevention, evaluation and appropriate management; and

Whereas, Physicians are aware of the increasing cost of medicine; and

Whereas, Physicians are trying to contain areas that may be associated with fraud and abuse; and

Whereas, Silent PPOs may interfere with patient-provider relationships by the following:

1. Not using financial or educational mechanisms to steer patient volume to preferred providers.

2. Allowing other insurers or self-insure plans access to PPO discounts AFTER services are provided, where a contract between the insurer/self-insurer and provider does not exist.

3. Using an arrangement similar to #2 above, but where a contract may exist; however, the patient is not identified as covered by the arrangement; therefore be it,

RESOLVED, That the Oklahoma State Medical Association initiate legislation related to silent Preferred Provider Organizations (PPOs) which prohibits an insurer or third party administrator (TPA) from reimbursing a provider on a discounted fee basis unless:

- The insurer or TPA has contacted the individual provider or a preferred provider organization that has a contract with the individual provider.
- The provider or organization of providers has agreed to provide services under the contract.
- The insurer or TPA has agreed to cover the health services under the policy.

The legislation should also prohibit a party to a preferred provider contract from selling, leasing, or otherwise transferring information about the contract or reimbursement terms without permission of the other contracting parties.

(ADOPTED AS AMENDED)

Resolution 8: Interest Charged on Billing Accounts

(A-2000)

Introduced by: Tulsa County Medical Society

Referred to: Reference Committee III

Whereas, The practice of medicine is an art and a science, and

Whereas, The delivery of health care is a business and should be provided as such, and

Whereas, The practice of third parties of unnecessarily delaying the reimbursement of claims made is onerous and costly to say the least, now therefore be it

RESOLVED, That the Oklahoma State Medical Association and its legislative arms work with the Oklahoma State Legislature and/or the State Insurance Commission to enact legislation to permit physicians to charge interest to ~~insurance companies~~ *third parties* on all accounts in excess of 45 days from billing.

(CONSENT CALENDAR)

Resolution 9: Health Care Financing Administration (HCFA) 1500 Claim Forms

(A-2000)

Introduced by: Tulsa County Medical Society

Referred to: Reference Committee III

Whereas, The practice of medicine is an art and a science, and

Whereas, The delivery of health care is a business and should be approached as such, and

Whereas, The multiple claim forms promote inefficiency and confusion, now therefore be it

RESOLVED, That the Oklahoma State Medical Association and its legislative staff work with the Oklahoma State Legislature and the Insurance Commission to mandate through either policy or legislation, the use of HCFA 1500 claim forms for all third parties operating in the state of Oklahoma.

(ADOPTED AS AMENDED)

Resolution 10: Private Contracting Under Medicare

(A-2000)

Introduced by: OSMA Organized Medical Staff Section

Referred to: Reference Committee III

Whereas, As a direct result of a provision in the Balanced Budget Act (BBA) of 1997; Sect. 4507, Medicare patients are restricted by federal law in their ability to go outside the Medicare system to spend their own money on a medical service of their choosing, and

Whereas, This provision generated intense reaction including litigation in federal court to have the law ruled unconstitutional. Indeed, in 1999, the U.S. Court of Appeals for the District of Columbia ruled that under certain conditions, a Medicare patient may enter into the equivalent of a private agreement with a doctor for medical services. However, the Health Care Financing Administration (HCFA) must rule that service to be "not covered" or "medically unnecessary" as well as "unwarranted," and

Whereas, This raised an intriguing problem. HCFA is engaged in an all-out campaign to stop fraud and abuse in Medicare, and it is targeting physicians and other practitioners who provide services that they deem "medically unnecessary." Therefore, resorting to an Advanced Beneficiary Notice (ABN)—a form given by the doctor to the patient notifying him that Medicare is not likely to pay for the medical service,

and by which the patient agrees to pay the doctor privately if Medicare does not—has, in the past, been grounds for Medicare to charge doctors with fraud and abuse for "medically unnecessary" services, and

Whereas, Congress should clarify the right of Medicare patients to spend their own money on the services of physicians of their choice, regardless of HCFA's views, and

Whereas, Representative Patrick Tooney (R-PA) has introduced "The Senior's Health Care Freedom Act" (HR2867) to guarantee the rights of seniors to contact privately regardless of HCFA's views, therefore be it

~~*RESOLVED*, That the Oklahoma State Medical Association actively lobby the Congress of the U.S. through the AMA, our OSMA federal lobbyist, and other avenues as appropriate for the passage of: "The Senior's Health Care Freedom Act" (HR 2867) as introduced by Representative Patrick Tooney (R-PA).~~

RESOLVED, *That the Oklahoma State Medical Association work for the passage of federal legislation to guarantee the rights of seniors to contract privately for medical services regardless of Medicare status.*

(ADOPTED AS AMENDED)

Late Resolution 11: Therapeutic Shoes

(A-2000)

Introduced by: Oklahoma Orthopaedic Society; Norman Dunitz, MD

Referred to: Reference Committee II

Whereas, Diabetes is a major medical problem affecting 22 million people in the United States, 15.7 million of whom are under the age of 65; and

Whereas, The medical and non-medical costs of diabetes in the United States was estimated by the American Diabetes Association to be $98 billion annually (1997); and

Whereas, It has been demonstrated that morbidity and the resulting cost of care for diabetic foot ulcers decrease when diabetic patients receive appropriate protective shoewear; and

Whereas, Under current federal law the Therapeutic Shoe Bill provides diabetic Medicare patients with appropriate protective shoes including custom-molded shoes, extra-depth shoes, inserts, and shoe modifications provided they are currently being treated under a comprehensive treatment plan and have one of the following:

1. peripheral neuropathy and callus formation,
2. history of pre-ulceration or ulcers with callus formation,
3. significant foot deformity,
4. previous amputation of a foot or part of a foot,
5. impaired circulation; therefore be it

RESOLVED, That the American Medical Association adopt the position that all diabetic patients enrolled in any public or private health insurance program who meet the eligibility criteria of the Therapeutic Shoe Act, should be provided appropriate therapeutic shoes as a covered benefit.

(NOT ADOPTED)

Late Resolution 12: Continuation of Medical Education and Indigent Care Mission of the University of Oklahoma Health Sciences Center

(A-2000)

Introduced by: Department of Emergency Medicine University of Oklahoma Health Sciences Center

Referred to: Reference Committee III

Whereas, recent developments in funding of education and indigent care have resulted in privatizing some of the functions of the University of Oklahoma Health Sciences Center (OUHSC), and

Whereas, the Joint Operating Agreement between the state of Oklahoma and the private corporation specifies that no existing academic program shall be harmed by this relationship, and

Whereas, subsequent to this agreement, program discontinuance proceedings have been initiated for the Department of Emergency Medicine and its Emergency Medicine residency program, and

Whereas, over the past 3 years there has been a sharp decline in the number of OU College of Medicine graduates who stay in Oklahoma for their residency training, therefore, be it,

RESOLVED, that the physicians of the OSMA continue to support the educational and indigent care mission of the OUHSC, and be it further

RESOLVED, that the OSMA immediately notify the Dean, Provost and Board of Regents that the Joint Operating Agreement, which prohibits the closure of existing academic programs and insures continuation of providing medical care to indigent and working poor of the State of Oklahoma, is not currently being respected, and be it further

RESOLVED, that the OSMA notify them of the necessity of maintaining a full complement of residency training programs at the OUHSC, so that the graduating medical students we have trained in Oklahoma can remain in Oklahoma for their residency training if they desire.

Eaton Named Physician of the Year by OU Medical Alumni Association

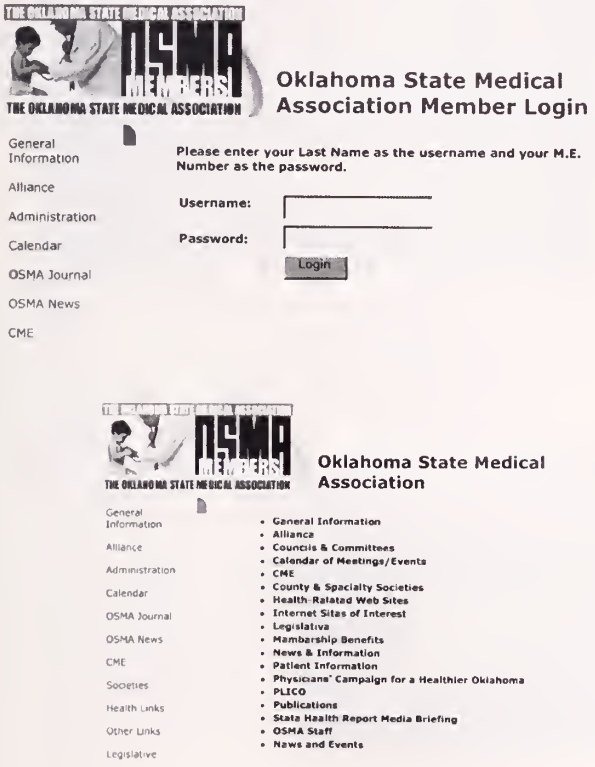
Bob Eaton, MD, of Edmond was named Physician of the Year in Academic Medicine by the University of Oklahoma Medical Alumni Association. Each year the Alumni Association honors Oklahoma physicians who, through their academic and practicing positions, further scholarship, education, and research and give outstanding medical education and patient care. Currently Dr. Eaton is chair of the Department of Radiological Sciences of University Hospital, Children's Hospital, and the Veterans Administration Hospital in Oklahoma City.

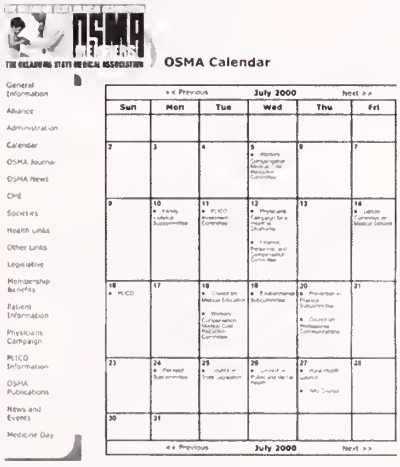
Woods Named to Physician Manpower Training Post

Mike Woods, MD, of Ochelata, has been appointed to the Physician Manpower Training Commission (PMTC) by Governor Frank Keating. Dr. Woods, a former recipient of the PMTC scholarship, is currently the program director of the University of Oklahoma College of Medicine-Tulsa Family Practice rural training site in Ramona. His appointment will undergo Senate confirmation, a process required for all appointments, during the next regular legislative session.

OSMA Web Site Offers Password Protection

The OSMA's new Web site, www.okmed.org, provides a new, updated look to the Association's Internet presence. In addition to the new flash technology and easy-to-use site menu, www.okmed.org is truly password-protected. To access the members' side of the site, OSMA members will be asked to enter their user name and password. Physician members accessing the members' side must enter their last name as the user name and M.E. number as the password. Requiring this login maintains the security of the site by preventing outside users from entering a general name and password (for instance, using "OSMA" as the password) to gain access to information intended only for OSMA members. If you do not know your M.E. number, please call OSMA Headquarters at 405/843-9571 or 800/522-9452 and the OSMA staff will be happy to assist you.





A username and password-protected login window appears when accessing the members' side of www.okmed.org, the OSMA's new Web site (above, left). Each OSMA member has a unique login consisting of the physician's last name and M.E. number. Once inside the site, a menu of options appears (left). Click on each to see more information about the Oklahoma State Medical Association, including a calendar of upcoming meetings and events sponsored by the OSMA (above, right). If you do not know your M.E. number, please call the OSMA at 405/843-9571 or 800/522-9452 and ask for assistance.

Domestic Terrorism Exercise Held in Oklahoma City

Oklahoma's first field training terrorism exercise was held on June 14 in Oklahoma City. A nerve gas attack was simulated at the Metro-Tech Vocational-Technical Center, Springlake Campus, as part of a nationwide drill in 112 cities. City hospitals were involved in the sarin attack scenario, which was conducted under the Oklahoma City Office of Emergency Management. Civilian and military organizations, including the Oklahoma City Institute for the Prevention of Terrorism, local and state police, military units, and the Federal Emergency Management Agency (FEMA), assisted with coordination and consultation on the drill. *Photos courtesy Dr. Arthur H. Schipul, Jr.*



Decontamination teams at University Hospital (above) and St. Anthony Hospital (below) await the arrival of victims of the simulated nerve gas attack.





Traffic control officers monitor the entrance to St. Anthony Hospital during the recent domestic terrorism exercise in Oklahoma City.



St. Anthony Hospital Emergency Room staff screen decontaminated patients. Police cadets served as simulated patients during the exercise.



Protective gear is worn by those who will have initial contact with the incoming patients affected by the gas.



Medical Explorer Scouts Post 1889 (sponsored by the Oklahoma County Medical Society), OUHSC medical students, and Dr. Arthur Schipul pause for a photograph at the conclusion of the day's exercise.

It's That Time—Back to School!

As thousands of Oklahoma children return to school, physicians across the state are helping to ensure their optimal health and well being through routine examinations and health education. The following information has been provided to assist you in addressing many of the needs and issues of your school-age population.

New immunization requirements for 1998 included the addition of varicella for grade K and hepatitis A vaccine for grades K and 7; in July 2000 the State Board of Health approved the use of Adult Recombivax HB (Hepatitis B vaccine, recombinant) in an alternate two-dose series for adolescents ages 11 to 15 to fulfill the hepatitis B vaccine requirement.

There are no **new** immunization requirements for the 2000-2001 school year.

Children with special health care needs may need a pnuemoccocal vaccination and an annual influenza vaccination.

Head lice outbreaks continue to indicate the need for utilization of a pediculicide in conjunction with a comprehensive eradication approach.

Children with special health care needs, including learning disabilities, may need a physician's statement to accompany them to school with their medications, and treatment protocols addressed.

Classroom behavioral issues frequently arise. A thorough age and developmentally appropriate assessment and evaluation may convey useful information for the parent and teacher.

Sports: Thorough sports physicals should occur annually. It is an ideal time to relate information on heat, frequent hydration, hypothermia, and the use and potential risks associated with steroid or nutritional supplement use to the student and family.

Many cultures rely on "folk-medicine" and religious practices to address their health issues and concerns. An awareness of these practices may assist you in the appropriate identification, intervention, and care of these children.

Annual screenings may include: vision and the "appropriate" tracking of the eyes; oral and dental care; hearing acuity and auditory processing abilities; age-appropriate speech and articulation abilities; height; weight; posture and scoliosis screenings; gait; and overall mobility.

Annual health visits present an excellent opportunity to provide client/parent education in regard to:

- child development issues and landmarks to expect;
- the importance of, and role in, parenting;
- age-appropriate sleep patterns and needs;
- the appropriate daily nutritional needs of children at different stages of growth and development;
- oral and dental care;
- tobacco, alcohol, and substance abuse issues;
- the safety of internet accessibility;
- puberty;
- school violence and safety (anger management, bullying, access to firearms, abuse issues, abduction, or stranger danger);
- date rape;
- mental health issues regarding children;
- indoor air quality (which may include second-hand smoke, asbestos, lead, etc.);
- hygiene and handwashing;
- the importance of physical activity and diet (nutrition);
- limiting time and exposure to television;
- the importance of reading to their child every night;
- types of child abuse (emotional, verbal, physical, and neglect) and resources; and
- guidelines for selecting quality child care and safety-related issues for "latch-key" children.

Many hidden hazards may also exist at school that you may want to encourage parents to be aware of, such as:

- Playground safety: a recommended 12" depth of shredded rubber, wood chips, or pea gravel may ensure fewer injuries.
- Bike helmet safety: the use of a bike helmet reduces the risk of head injury by approximately 80%. Proper size and fit are crucial.
- Soccer goals: unchained soccer goals may tip over and crush or injure a child.
- Indoor air quality: school buildings may harbor many potential allergens or utilize cleaning chemicals or insecticides that may trigger asthma or allergic reactions. Indoor air quality tool kits for schools exist and may be obtained to ensure that the air at school is clean and safe for all.

Many schools in Oklahoma have begun to bill Medicaid through the Oklahoma Health Care Authority for health-related services that are provided in the school setting to Medicaid-eligible students. An occupational therapist, physical therapist, speech therapist, social worker, licensed professional counselor, or school nurse may provide these services. For the 1999-2000 school year, case management was included with the types of services that may be provided and billed. However, in the 2000-2001 school year, many changes will occur within the program, limiting or changing some of the services that were previously allowed. Overall, these services may assist you in the care of your school-age patients.

For more information about school health, please contact the Child and Adolescent Health Division, Maternal and Child Health Service, Oklahoma State Department of Health at 405/271-4470, or check our Web site at: www.health.state.ok.us/program/shcc/index.html.

Instructions for Authors

Contributions

Articles submitted for publication become the sole property of the *Journal* and must not have been published elsewhere. The Editorial Board reserves the right to edit any material submitted.

Manuscripts must be formatted in a standard typeface, and the text must be double-spaced. Authors are required to submit their manuscripts on computer disk, preferably in Microsoft Word or WordPerfect (any PC version) or ascii/ansi/dos text. The disk must be clearly labeled with the manuscript's title, author, and format. Two clean printed copies of the document file(s) must accompany all submissions.

Biographical information for each contributing author must accompany the manuscript submission. This information must include: name, gender, mailing address, telephone number, fax number, school of graduation and year, specialty (if any), and current position, title or practice as it relates to the manuscript.

The *Journal* does not assume responsibility for the statements or opinions of any contributor.

Style

All manuscripts should approximate the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual of Style* (9th Edition). An abstract of 150 words or less should accompany each manuscript, stating the exact question considered, the key points of methodology and success of execution, the key findings, and the conclusions directly supported by these findings.

Bylines may contain no more than **six** (6) names and shall include only those individuals who can attest that they have contributed to the conception and design or analysis and interpretation of data, drafting the article or revising it critically for important intellectual content, and the final approval of the version to be published. Other contributors may be recognized in an acknowledgment.

All references must be listed in their order of appearance in the manuscript and must conform to the style used in both the *Journal* and *JAMA* (for example: Richter RW, Farlow MR. Recent advances in the treatment of Alzheimer's. *J Okla State Med Assoc*. 1998;91(8):431-437.). Footnotes, bibliographies, and legends for illustrations should appear on separate sheets.

Accompanying Materials and Illustrations

Materials other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations must be labeled with the author's name and must be numbered in the order to which they are referred in the article. Tables and figures must also be identified in the order to which they are referred in the article and must be accompanied by an appropriate title or cutline. The quality of all accompanying materials must be in keeping with the quality of the magazine.

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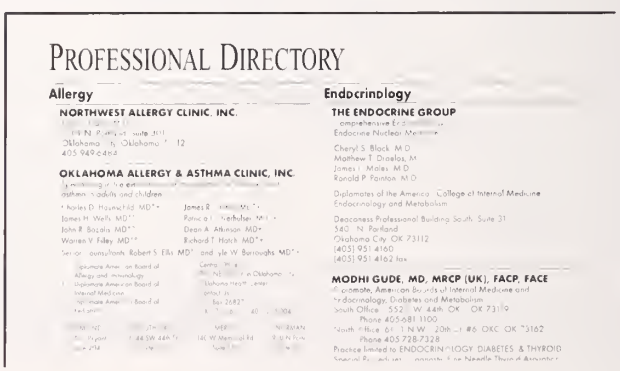
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Webb M. Thompson, Jr., MD August 20
Perry A. Lambird, MD August 25
Nolen L. Armstrong, MD September 12
George R. Randels, MD October 2
George B. Carter, MD October 7
John Robert DeBiase, MD October 17
Theodore Turnbull, MD October 19
Sol Wilner, MD October 31
Malcolm Horne, MD November 3
William Clark Cheek, MD November 11
Bill B. Elrod, MD November 17
Donald E. Johnson, MD November 18
Allen E. Greer, MD November 19
Beverly Colvin Chatham, MD December 2
Norman A. Cotner, MD December 3
Alan Knight Braly, MD December 9
Wilson David Steen, PhD December 12
James Thermon McInnis, MD December 18
Douglas Lyons Polk, MD December 19
Thomas S. Llewellyn, III, MD December 26
John Preston McDaniel, MD December 27
Joe Earle Tyler, MD December 31

2000

Hwan X. Youn, MD.....January 2
Donald Charles Barney, MD.....January 4
Charles E. Cook, MD.....January 13
Lynn H. Harrison, MD.....January 16
Kenneth C. Hoffman, MD.....January 17
Richard E. McDowell, MD.....January 17
Wilson E. Roark, MD.....January 28
Orval L. Parsons, MD.....January 29
James William White, MD.....February 1
Harry L. Deupree, MD.....February 3
James L. Nicholson, MD.....February 3
Leo Meece, MD.....February 5
Homer A. Ruprecht, MD.....February 6
William G. McCreight, Sr., MD.....March 10
Armond H. Start, MD.....March 30
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Willis E. Lemon, MD.....April 21
Roy A. Lawson, MD.....April 22
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Obituaries

Wilson E. Roark, MD
1926-2000

Wilson E. Roark, MD, died January 28, 2000. Born October 28, 1926 in Plainview, Texas, Dr. Roark received his medical degree from Louisiana State University in 1949. From 1949 to 1953, Dr. Roark served in the United States Air Force. He was a member of the Oklahoma State Medical Association.

Jack G. Glasgow, MD
1918-2000

Jack G. Glasgow, MD, died June 7, 2000. Dr. Glasgow was born May 5, 1918 in Alva and received his medical degree from the University of Oklahoma School of Medicine in 1942. He served as a medical officer in the United States Army, reaching the rank of First Lieutenant. Dr. Glasgow was a life member of the American Academy of Family Physicians and the Oklahoma State Medical Association.

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Deaconess Hospital: Yvonne Curtright 405/604-4979

Aug.	3,10,17 24, 31	Cancer Conference	7:00 am	1 hr each
August	21	Diabetes Management and Wound Care	6:30 pm	1 hour

Institute For Mental Health: Shannon Manning 405/573-8225

August	21	"Risk Assessment of the Mentally Ill Individual"	8:30 am	6 hours

Mercy Health Center: Debbie Stanilla 405/752-3806

August	3	"The Changing Landscape of Therapeutic Options in Asthma"	12:15 pm	1 hour
August	10	Fungal Infections in Surgery Patients	12:15 pm	1 hour
August	16	Ethics For Lunch: "Unbraiding the Rope: Ethical Issues In Managed Care"	Noon	1 hour
August	17	Dermatology Update	12:15 pm	1 hour
August	23	Tumor Board: "Low-Grade Lymphomas"	7:00 am	1 hour
August	24	"Cost-Effective Use of Antibodies"	12:15 pm	1 hour
August	31	Sexually Transmitted Diseases	12:15 pm	1 hour

Shawnee Regional Hospital: Jackie Owen 405/878-8140

August	24	"Management of CHF"	Noon	1 hour

St. Anthony Hospital: Sandy Coury 405/272-6358

August	3	Cancer Conf. Presentations: TBA	7:00 am	1 hour
August	16	"Three-Dimensional Ultrasound With Demonstration of 3-D Ultrasound Unit"	Noon	1 hour
August	17	Cancer Conf. Presentations: TBA	7:00 am	1 hour
August	17	Behavioral Medicine Share: "The Making of an Adolescent Sex Offender"	11:45 am	1 hour
August	21	Grand Rounds: "Alternative Medicine"	8:00 am	1 hour

St. John Medical Center: Gail Hilst 918/744-2875

August	3	Critical Care Conf.: Toxic Shock Syndrome	Noon	1 hour
August	8	Critical Care Conf.: Head Trauma and ICP Monitoring	Noon	1 hour
August	10	Critical Care Conf.: CXR Interpretation in ICU	Noon	1 hour
August	15	Critical Care Conf.: Problem Bleeding in the ICU and Postoperative Patient	Noon	1 hour
August	17	Critical Care Conf.: Vents & Weaning	Noon	1 hour
August	24	Critical Care Conf.: TIP HUS Syndrome	Noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator at 405/843-9571 or 800/522-9452.

Alliance Membership: Its Everyone's Concern!

Membership—how to recruit members and how to keep them—seems to be the number one concern of Alliances on the local, state, and national levels. As 2000-2001 OSMA Alliance first vice-president, my primary interest is membership development. Throughout the year, I will be keeping in close contact with the membership chairs in counties across the state. If your county has not filled this position, I urge you to do so. Membership is an ongoing and sometimes time-consuming project.

Those of you who are already members have witnessed the impact of changing times, changing lifestyles, and the ever-changing dynamics affecting the practice of medicine. We are attempting to understand the complex issues that impact the way our spouses practice medicine. One of our goals is to meet the challenge of these changes.

Remember, though, that your membership committee can't fix everything. As you begin your Alliance year, keep in mind that everyone should help with recruitment and retention. In this day and age, getting and keeping members is most directly tied to the question, "Is this organization filling my needs?" Personal contact with non-members as we go about our day-to-day activities can be the key to encouraging new physician spouses to join and can enhance the image of our organization.

We have so much to offer, and we need to get that message to other prospective members. For example, local, state, and national Alliances have made great strides in stopping violence with our highly successful SAVE (Stop America's Violence Everywhere) program. Millions of dollars have been turned over to our medical schools for research and scholarships through the AMA Foundation. Many counties participate in legislative desserts where state House and Senate representatives meet with spouses and physicians in small groups. Of course, all counties are hopefully participating in Medicine Day at the Capitol. These programs have given our organization a real voice in the direction of medicine.



Andrea Jones, OSMAA First Vice-President

If you are not a current member, I urge you to make the commitment of becoming a part of this worthwhile organization. Please call your local membership chair or president for details. Those of you living in an area with no organized group don't need to be left out, either. You are eligible for membership as a M.A.L. (Member-at-Large). Vice-president of M.A.L.s this year is Debbie Zanovich, who can be reached at 918/743-4750.

Our Alliance has a strong place in today's world—perhaps a stronger place than it has ever had in its 75+-year history. Our combined concerns and shared challenges bind us together into a vital organization meeting the needs of our physicians and their families in the 21st century.

p.s. Physicians, if your spouse is not a member of the Alliance, please take home this article to share with him or her!

"Personal contact with non-members as we go about our day-to-day activities can be the key to encouraging new physician spouses to join and can enhance the image of our organization."

THE NEW YORK ACADEMY OF MEDICINE
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THE LAST WORD

CDC Releases Annual Report on Youth Risk Behavior

Since 1991, the incidence of many injury-related behaviors has decreased among high school students throughout the United States, according to the 1999 Youth Risk Behavior Surveillance System (YRBSS) report released by the Centers for Disease Control and Prevention (CDC). Behaviors that show a significant decreasing trend during the past decade include the percentage of students who never or rarely wore seatbelts (37% decrease), carried a weapon (34% decrease), and ever had sexual intercourse (8% decrease). Nonetheless, many high school students continue to practice behaviors that place them at risk for serious health problems. In the United States, nearly three-fourths of all deaths among persons aged 10 to 24 result from four causes: motor vehicle crashes (31%), other unintentional injuries (11%), homicide (18%), and suicide (12%). Additionally, the report finds that teen smoking has increased among survey participants. In 1991, 27.5% of the students surveyed reported they had smoked at least once in the previous month. That figure increased to 36.4% in 1997, then dropped to 34.8% in 1999. Frequent cigarette use climbed from 12.7% to 16.8% over the past decade. To view the findings of the 1999 YRBSS, visit the CDC Web site at www.cdc.gov and click on "Press Releases."

OSDH Initiates Electronic Birth Certificate System

The Vital Records Division of the Oklahoma State Department of Health has begun implementing an electronic system to report and file birth records. The Electronic Birth Certificate (EBC) will help hospitals complete birth records by offering a user-friendly system for completing and printing the birth record. The EBC will also allow for a more accurate and expedient reporting of data contained on the birth certificate.

To complete the birth record accurately, cooperation between all hospital staff and the attendant at birth will be necessary. In accordance with Oklahoma statutes, physicians must furnish the medical information necessary to complete the certificate, including medical complications, medical testing, complications of labor/delivery, abnormal conditions of newborn, obstetric procedures of delivery, and congenital anomalies.

For more information, please contact John C. Burks, State Vital Records Registrar, at 405/271-2224.

Cigar Labels to Include Health Warnings

The Federal Trade Commission (FTC), the U.S. Surgeon General, and the nation's largest cigar manufacturers recently reached an agreement that would require manufacturers to clearly and conspicuously include warnings on cigar packages and advertisements. This is the first national requirement for health warnings on cigar products. The settlement was in response to FTC allegations that the failure of cigar companies to disclose the health risks of cigar smoking has been deceptive and unfair. Seven companies were involved in the agreement, comprising approximately 95% of the U.S. cigar market.

The settlement outlines specific format requirements designed to ensure that the warnings are visible and readable, and are intended to create a uniform national system of rotating health warnings. The rotating warnings are as follows:

- SURGEON GENERAL WARNING: Cigar Smoking Can Cause Cancers Of The Mouth And Throat, Even If You Do Not Inhale.
- SURGEON GENERAL WARNING: Cigar Smoking Can Cause Lung Cancer And Heart Disease.
- SURGEON GENERAL WARNING: Tobacco Use Increases The Risk Of Infertility, Stillbirth, And Low Birth Weight.
- SURGEON GENERAL WARNING: Cigars Are Not A Safe Alternative To Cigarettes.
- SURGEON GENERAL WARNING: Tobacco Smoke Increases The Risk Of Lung Cancer And Heart Disease, Even In Nonsmokers.

The orders contain provisions that narrowly preempt state laws requiring different health warnings on cigar products. This provision does not affect any other state or local requirements, such as restrictions on advertisement placement or youth access to tobacco products. The Commission voted to accept the consent agreement for public comment and, following a 30-day public comment period, will decide whether to make the agreement final.

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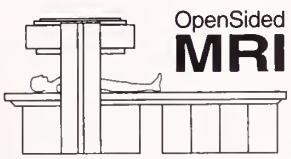
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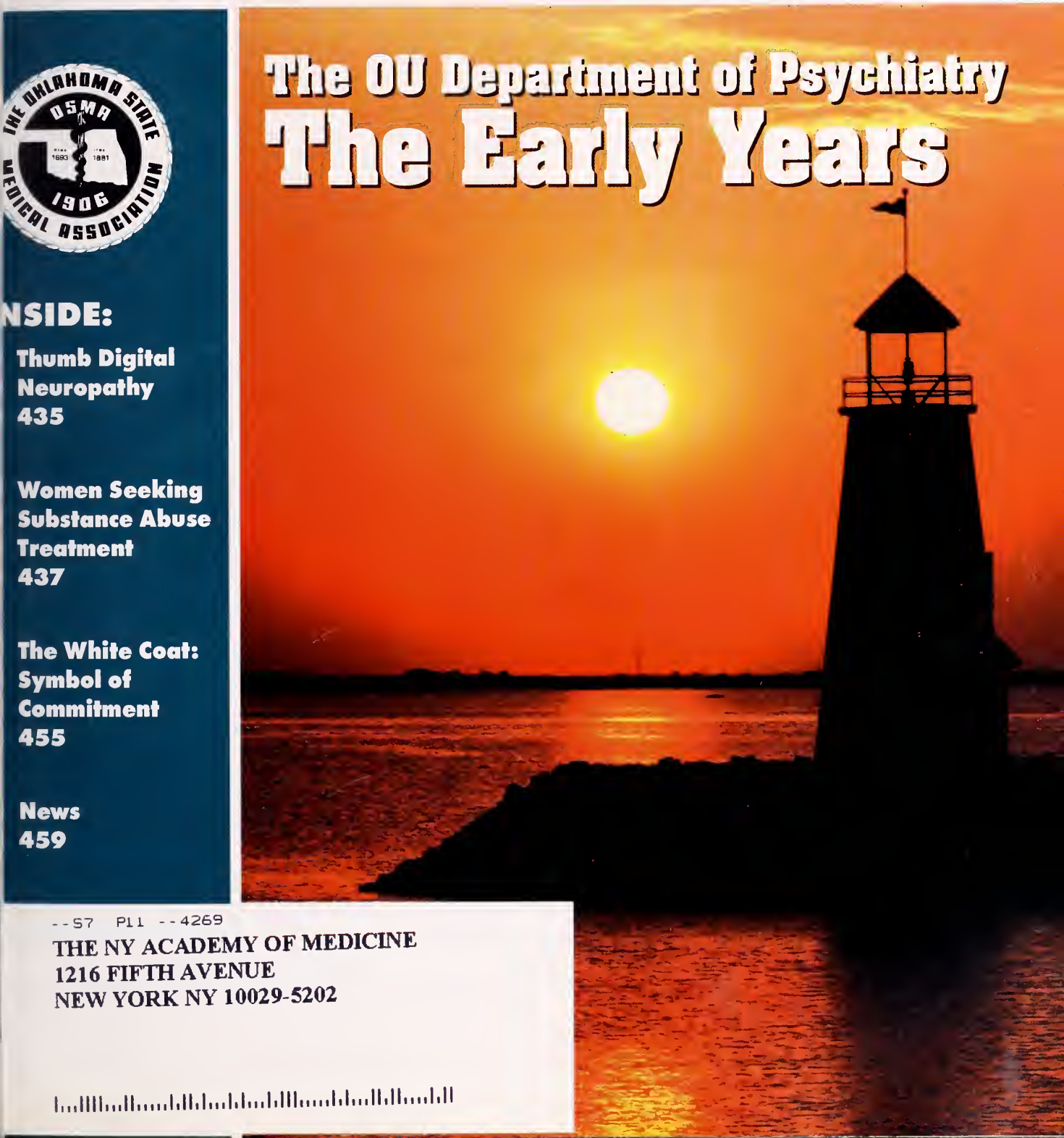
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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION



INSIDE:

Thumb Digital Neuropathy
435

Women Seeking Substance Abuse Treatment
437

The White Coat: Symbol of Commitment
455

News
459

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SEPTEMBER 2000 VOL. 93, NO. 9

EDITORIAL

Remembering September 431
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE

Welcoming the Next Generation 433
ROBERT J. WEEDN, MD, DUNCAN

SCIENTIFIC

Thumb Digital Neuropathy Caused by Splinting 435
ERIC M. KAGEL, MD, SAN JOSE, CALIFORNIA; GHAZI M. RAYAN, MD, OKLAHOMA CITY

SPECIAL

An Overview of Women Seeking Substance Abuse Treatment in Oklahoma 437
RICHARD P. TRAUTMAN, MD, OKLAHOMA CITY; MARY E. PHILLIPS, OKLAHOMA CITY; GENE HALLFORD, OKLAHOMA CITY; GARY K. BORRELL, MD, OKLAHOMA CITY; SARA JO NIXON, PHD, OKLAHOMA CITY

SPECIAL

The Early Years: Jolly West and the University of Oklahoma Department of Psychiatry 446
RICHARD GREEN, OKLAHOMA CITY

WORTH REPEATING

The White Coat: Symbol of Commitment 455
M. DEWAYNE ANDREWS, MD, OKLAHOMA CITY

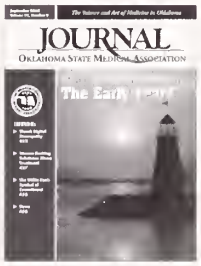
Welcoming Remarks to the Class of 2004 458
DEBORAH MCALISTER, MS-IV, OKLAHOMA CITY

NEWS

Oklahoma City Physicians Headed to Sydney, 459...Celebrating Women in Medicine Month, 459...Summer Fun at the Bricktown Ballpark, 460

DEPARTMENTS

From OSMA Legal Counsel, 461... Letters to the Editor, 462... In Memoriam, 463...CME, 466...Alliance, 467...The Last Word, 468



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Remembering September

It is the time of year that always reminds me of the anxiety and excitement that accompanies the anticipation of returning to school. Another set of teachers, another set of classes, and another set of friends. Who was going to come back, who moved away, and what would be the world that I lived in for another school year?

Do you remember the new pair of blue jeans that had to be rolled up? At my house they were purchased in September to last the whole year, anticipating the growth spurt that inevitably occurred. The new clothes, a new binder, and a new "improved" set of ink pens.



As the days move forward into September, I cannot leave these memories behind me. They are part of the cycle of life that surrounds me to this day.

Sure, my office staff doesn't really want me wearing rolled-up jeans to the office. And they would give me bizarre looks if I came in with a new notebook. But I always try to sneak in a new pen or set of underlining markers in memory of the start of school. I think my office folks just smile to themselves when they note my annual ritual.

Do you remember the first summer that you did not have to prepare for school? After graduating from residency in June there is that first summer of practice. I remember waking up on a cool September morning, smelling a bit of moisture in the air and facing the fact that I would not be required to set foot inside a classroom ever again.

Part of me leapt with joy, while another part of me was saddened.

I know that you are anticipating this editorial to drift off onto the importance of continued education in our profession, but indeed that is not my intent. Rather, I wanted to take a moment to reflect on the cycles of our lives that have been useful in producing our work ethic, our commitment, and our vision.

I used to spend my summers in the public library. I would go from shelf to shelf, aisle to aisle, picking up books to read. Cracking each cover, I would read the first few pages; if it caught my interest I would continue, otherwise I would put it down and move on. As a child, I was addicted to reading. As an adult, I have guilt about my reading.

Are you like me—do you find it hard to slow down and relax? I don't remember ever being taught how to do this. I suffer from long work weeks and sleep deprivation on a regular basis. I am sure that I am no different than you. But I rarely take advantage of my time off to really relax and renew my "life batteries."

And then there is the guilt about reading something frivolous or non-medical…

My brother-in-law, who has a PhD in education and teaches at the Air Force Academy, taught me how to "speed read" a couple of summers ago (he has perfected a reading technique they train the cadets). I must admit that it was an extreme act of freedom for me. I can now read wonderful non-medical books at an extremely rapid pace, rationalizing my guilt away by balancing the short amount of time spent reading the text. The books that I am able to read often broaden my experience and give me a fresh look at the world, rather than the standard world-view of the doctor's lounge.

Over the years, I have found friends and colleagues who will discuss their reading with me. They recommend books from their reading lists or advise me to leave another book alone. Again, in my rationalizing way, this increases my efficiency, making my non-medical reading easier to accept.

This whole discussion is foreign to some of you. You have never struggled with your choice of reading. I admire and envy you. Someday someone will have to explain to me how you developed that mindset.

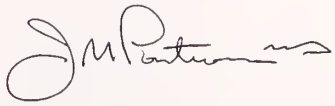
And then there is the question of the loss of books in the era of computerization.

How will the next generations of students and physicians know about the joys of turning a page, smelling the ink and paper of an old, cherished book? My memory is still jogged to the anatomy lab each time I open my copy of *Gray's Anatomy*, catching the faint odor of formaldehyde that drifts out from those hallowed pages. They comfort me as I remember the many hours of study and dissection.

Have they created computers that capture the smell of formaldehyde?

Thanks for allowing me a moment to remember Septembers past. It is still a point of change in my life cycle. September always finds me refocusing and renewing my efforts. Whether it is the clinical work, or the reading, or just the joy of smelling early September mornings, we all have to go through the process.

Now, where are those markers I bought last week?



J. Michael Pontious, MD
Editor-in-Chief

"My memory is still jogged to the anatomy lab each time I open my copy of *Gray's Anatomy*, catching the faint odor of formaldehyde that drifts out from those hallowed pages...Have they created computers that capture the smell of formaldehyde?"

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA

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President's Page

Welcoming the Next Generation

Last year as President-elect, and again this year as your President, I had the pleasure of addressing the incoming class of medical students at the OU College of Medicine White Coat Ceremony for the class of 2004. This is an extraordinary annual event instituted four years ago by the OU College of Medicine. I want to especially thank Dr. Jerry Vannatta, Executive Dean, for including the Oklahoma State Medical Association in this inspirational event. Elsewhere in this issue of the *Journal* you will find the full text of the speech given by Dr. Dewayne Andrews, Associate Dean of Academic Affairs and the principle speaker during the White Coat Ceremony. His words not only recount a solemn entreaty to the incoming medical students, they also serve as a reminder to us all of what our profession is about. Read it—it will rekindle your spirit.



This month's President's Page features my comments at this year's White Coat Ceremony.

"It is an honor and a privilege to be here today on behalf of the 5000+ members of the Oklahoma State Medical Association. We congratulate you on your many accomplishments to date and your choice of careers as you enter medical school—truly a great milestone in each of your lives and the lives of those who love you. Your goal to learn the art and science of medicine is complemented by the Oklahoma State Medical Association's mission to promote the art and science of medicine by serving as an advocate for physicians and their patients.

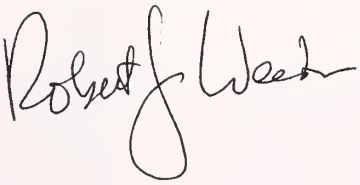
Today I would like to talk about three topics: genetics, prevention, and the four Cs.

First, genetics. This is no ordinary time. It is said that within the last fifty years there has been more progress in the physician's ability to care for his fellow man than has been recorded in medical history, dating back to the Egyptians 5000 years ago. I think that the application of genetic knowledge and technology will eclipse all of that progress in the next decade. This knowledge will truly revolutionize medical practice, but in so doing will create ethical challenges.

The second topic is prevention. Most of our patients' problems have been created by their own lifestyles. Genetics may load the gun, but we pull the trigger on ourselves. The Oklahoma State Medical Association's Physicians' Campaign for a Healthier Oklahoma is about wellness promotion and behavior modification—in patients and the public—to create healthier lifestyles. We live in a sedentary, overweight, stressed-out, self-indulgent society. We must learn to teach patients as well as treat them, prevent as well as heal. The Task Force that created the Physicians' Campaign and the OSMA leadership are working hard to stimulate physicians and anyone who will partner with us to promote this program. Medical students and residents alike are represented on the Task Force. We hope that you will join this effort also.

The third thought that I would like to leave you with is to encourage you to pursue your career in medicine, always keeping in mind the four Cs: competence, character, commitment, and, most of all, compassion. Most of you are quite idealistic at this point in time. Don't let that idealism burn out. Don't become cynical. Approach medicine with your heart as well as your head and you'll find great satisfaction. There is no better time to be a physician.

In closing, the slogan for the Physicians' Campaign for a Healthier Oklahoma is 'Your health, your life, your choice.' Make healthy choices for yourself as you pursue your career. After all, what we put into our bodies and what we do with and to our bodies ultimately determines our own health. If you do not enthusiastically embrace a preventative lifestyle for yourself, you will not be a good example for your patients and will not actively promote appropriate lifestyle choices for them. Ultimately, the campaign is about longevity and the quality of life—yours, mine, your friends, relatives, patients, and all those you touch. The PCHO always closes with the statement 'We wish you well.' I, too, will close with that statement. I wish you well."



Robert J. Weedn, MD
OSMA President

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Thumb Digital Neuropathy Caused By Splinting

Eric M. Kagel, MD; Ghazi M. Rayan, MD

Healthcare professionals are currently faced with a great variety of splints and splinting materials. Choices range from prefabricated products to custom splints made on-site from plaster, orthoplast, or fiberglass. In addition to providing immobilization to maintain a particular posture, a splint must protect important soft tissues. Patients with hand or wrist injuries often receive a prefabricated metal cock-up wrist splint in emergency departments. Complications from splints are not uncommon but are infrequently reported.[1,2] We report a case in which a metal wrist cock-up splint caused compression of the thumb ulnar digital nerve. Preventive measures for such complication are included.

Case Report

A 17-year-old, right-handed female was treated in a local emergency room for an injury she sustained to the right hand. As she was stepping out of an automobile, she lost her balance and struck the dorsum of the right hand against the ground. The patient experienced pain and developed swelling on the dorsum of the hand. X-rays were obtained in the emergency room and did not show any bony abnormalities. A diagnosis of soft tissue contusion was made. The patient was given a prefabricated metal wrist cock-up splint that maintained the wrist in mild extension and digits in a neutral position.

The patient was seen in the clinic one week after her injury. She had kept the metal splint in place since the ER visit. During the office visit she had a new complaint that was not related to the injury. In the last several days the patient had been experiencing paresthesia on the ulnar aspect of the thumb, along with discomfort at the base of the thumb. Physical examination revealed localized ecchymosis measuring 4 × 8 cm on the dorsum of the right hand over the ring finger metacarpal, mild swelling, and focal tenderness in the same region. These findings were consistent with her initial injury. In addition, she had sensory deficit with absent light touch sensibility and two-point discrimination in the distribution of the ulnar digital nerve of the thumb. The skin of the thumb was normal; digital Allen test showed normal arterial flow, and capillary refill in the nail bed was normal.

The sharp edge of the metal splint was impinging against the base of the thumb at the metacarpalphalangeal joint level and was the cause of this neurologic complication (Figure 1). The splint was replaced by a well-padded, short arm volar plaster splint designed to maintain the wrist in a neutral position, leaving the thumb and fingers free. The distal edge of the splint ended at the midpalmar crease, allowing the metacarpalphalangeal joints a full range of motion. The padded splint supported the thenar mass without applying pressure at the base of the thumb.

Two weeks after the initial office visit the patient's condition had resolved. The ecchymosis on the dorsum of the hand was no longer present, nor was the swelling or tenderness. The patient had full range of motion of the wrist including flexion, extension, and forearm pronation/supination. Neurologic findings were now normal in the ulnar digital nerve distribution of the thumb.

Discussion

Splints are either static for immobilization or dynamic to allow controlled mobility. The purpose of static splinting is to rest the injured part and protect the damaged tissues from addition-

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Figure 1. The affected thumb showing the area of sensory involvement. The area shaded is completely anesthetic.

al trauma. Pressure on the tissues is more often inflicted by a prefabricated than a custom-made splint. Prefabricated splints tend to be either too tight or too loose, and both splints can localize pressures to the adjacent tissues, including skin and neurovascular structures. While metal splints, which are available in most emergency rooms, come in three sizes, not all hands can conform. Custom-made splints, especially those made of plaster, allow better molding and uniform contact with tissues.

Digital nerve compression in the thumb has been reported frequently among avid bowlers, giving this condition the name "bowler's thumb."[3,4] This compression neuropathy is caused by extraneural mechanical pressure on the ulnar digital nerve of the thumb. The same condition can also be caused by a poorly designed splint.

Peripheral nerve compressive lesions have been divided by Sunderland into acute and chronic types.[5] Acute compression is a transient process that leads to a nerve conduction block. In severe cases the vascular blood flow to the nerve is compromised and wallerian degeneration develops. The chronic type occurs over a greater period of time and generally has a less favorable prognosis; one example is chronic median nerve compression in the carpal tunnel.

Dobyns has described four risk factors for ulnar digital compression neuropathy of the thumb.[2] First, the ulnar digital nerve is immediately beneath the skin, which enables the nerve to be readily palpated. Second, the nerve travels directly over bony structures, most importantly the ulnar sesamoid bone. Third, the nerve has a fixed position with minimal excursion. Fourth, the patient does not experience pain from the nerve trauma, only subsequent numbness.

When rigid prefabricated splints such as the cock-up variety are used, it is imperative that the patient be instructed to remove the splint daily to check for any pressure areas. If the sharp edges are found to apply pressure to the adjacent tissues, the edges should be smoothed or the splint replaced with a plaster-type splint. In the case of fracture immobilization, the metal splint is contraindicated since daily removal would risk fracture displacement.

In our patient, the hard edge of the metal splint caused the nerve to be compressed between the firm edge of the splint and the ulnar sesamoid bone, inflicting nerve injury with subsequent sensory deficit. The patient's symptoms recovered after eliminating the cause of nerve trauma because her nerve injury was not severe. Prolonged severe nerve compression can lead to permanent nerve damage. An understanding of thumb anatomy and the adverse effects of an ill-fitting splint may prevent this complication. J

The Authors

Eric M. Kagel, MD, at the time this article was written, was a hand surgery fellow. Currently he is in private orthopedic practice in San Jose, California. Ghazi M. Rayan, MD, is a clinical professor of orthopedic surgery at the University of Oklahoma Health Sciences Center and director of the hand surgery fellowship program at Integris Baptist Medical Center.

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An Overview of Women Seeking Substance Abuse Treatment in Oklahoma

Richard P. Trautman, MD; Mary E. Phillips; Gene Hallford; Gary K. Borrell, MD; Sara Jo Nixon, PhD

Current studies of neurocognitive function in alcoholics are generally restricted to a relatively small subsample of persons seeking treatment. Subjects are typically excluded from study if reporting signs or symptoms of possibly confounding disorders such as comorbid psychiatric disorders, medical, or neurologic disorders. Thus, the question arises as to whether those individuals who actually participate in these reported studies are representative of the larger population of unselected persons. Studies of women are particularly subject to this concern due to higher rates of comorbid medical and psychiatric disorders in women. The current study was directed to contrasting treatment-seeking women who either were or were not selected for a laboratory study of neurocognitive function. Specifically, we compared subgroups of women identified on the basis of the presence of an alcohol use disorder and/or being selected for study. A total of 638 women were available for comparison. Contrary to anticipated concerns, analysis of basic demographic, alcohol and drug use, and affective/cognitive measures revealed considerable similarities among the groups. Consistent with other literature, the large majority of these women reported a family history of alcohol use disorders. They also reported a preference for stimulants as opposed to other illicit substances as evidenced in self-report of their most frequently used drug in the six months prior to treatment (excluding alcohol). These findings suggest that current selection procedures, although necessarily biasing samples in response to specific questions, do not result in samples that are significantly different from the majority of treatment-seeking women, at least on the basis of demographic and affective variables. Furthermore, as described herein, these findings have specific indications for primary care assessment and treatment referral.

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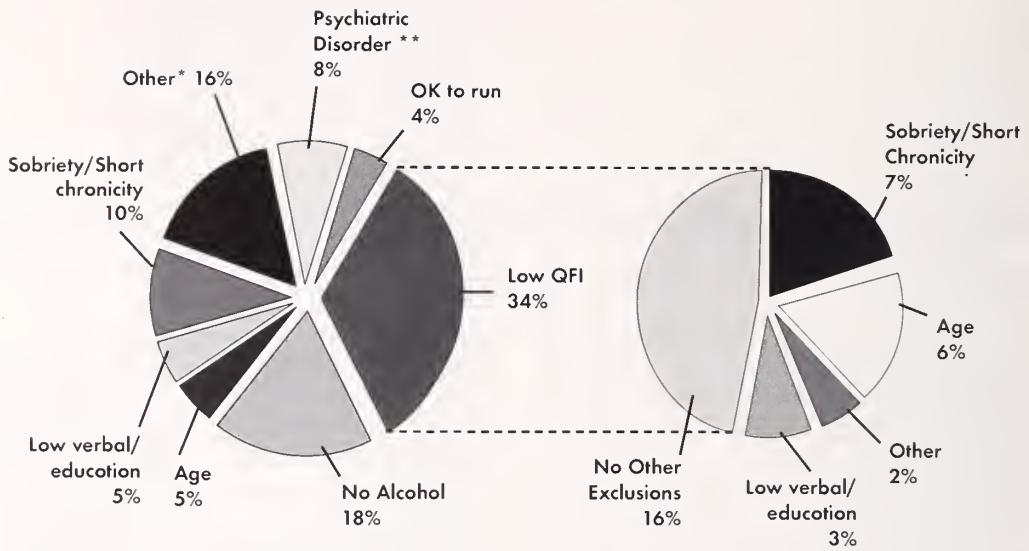
Introduction

The long-term effects of chronic excessive alcohol use have been the focus of much research in both the basic and applied sciences over recent decades. Research indicates that the persistent, excessive use of alcohol is associated with a host of negative physiological and psychological/psychiatric consequences including increased rates of certain cancers, cardiovascular disease, and affective disorders.[1-5] Although the precise etiological relationships are not well-defined for some of these associations, it is clear from both laboratory and epidemiological studies that alcohol misuse is associated with a wide array of negative outcomes.[3,6]

Initially, alcohol research was largely restricted to male volunteers who were generally recruited from Veteran's Administration hospitals. However, over the past two decades, increasing attention has been directed to the study of alcohol use disorders (AUDs) in women.[7-12] This research suggests that women may be differentially sensitive to the negative consequences of alcohol misuse. Studies suggest that women may be more susceptible to alcohol-related liver disease, cardiovascular disorders, and neurocognitive dysfunction,[7-8,11] and progress more quickly from first getting drunk regularly to first encountering drinking problems.[13] These studies are particularly alarming given data indicating that heavier alcohol consumption is generally initiated in young adulthood—a period of childbearing, educational completion, and relationship development.[12]

Over the past two decades, research has also focused on the neurocognitive concomitants of chronic alcohol misuse. Specifically, programmatic research has focused on detoxified female and male participants who meet clinical diagnosis for AUDs (either alcohol abuse or alcohol

Figure 1. Reasons for Exclusion: Women in Treatment



* Other = Medical Disarder, currently medicated, etc.

** Psychiatric Disarder = DIS-IV Axis I Psychapothalogy Indicated

The numbers in this figure represent anly the primary reason for exclusion (ie, each subject is represented only once). Many subjects met multiple exclusianary criteria.

dependence; DSM-IIIR[14] or DSM-IV[15]) but fail to exhibit indicators of the Werknicke-Korsakoff Syndrome or alcoholic dementia. This work has revealed alcohol-related deficits in a variety of neuropsychological domains including abstracting performance, visual-spatial learning and memory, perceptual-motor skills, and verbal learning and memory.[16-20]

There are also significant alcohol-related changes in the underlying brain neurophysiology as reflected in aberrations of the event related potential (ERPs). ERPs are alterations in the brain's electrophysiology associated with the presentation of stimuli. Alterations in ERPs associated with target detection, selective attention, and higher cortical semantic processing have also been reported.[21-26] Finally, current neuroimaging studies reveal abnormal brain metabolism, neuronal and glial cell loss, demyelination, and mammillary body as well as cerebellar shrinkage.[27-34] In summary, research reveals that chronic alcohol abuse/dependence is associated with widespread functional and structural changes in brain even after detoxification.

One of the strengths of many of these studies is the control that has been executed over the selection and testing of subjects. Because the fundamental interest has been in exploring the long-term neurotoxic effects of alcohol, exclusionary criteria have generally included neurologic (eg, epilepsy), medical (eg, chronic obstructive pulmonary disease), and/or psychiatric disorders (eg, major depressive disorder, psychotic disorders) that might separately or interactively affect neurocognitive function and thereby confound interpretation of outcome. Typically, a large number of potential participants are screened before an appropriate sample is recruited. In alcohol studies, the proportion of persons eligible to participate in studies of neurocognition is particularly small due to the generally high rates of complicating medical and psychiatric comorbidity.[1,4-5] Although conservative recruitment increases confidence that observed differences are alcohol-related, it also introduces a considerable limitation. Specifically, the generalizability or external validity of the findings may be substantially restricted.

Given the increased prevalence of certain psychiatric disorders in women, the likelihood of a differential sensitivity to medical consequences as well as the historically low proportion of women seeking treatment, the impact of this selection approach may have substantive impact on interpreting studies of alcoholic women.[10,35] A recent review of our selection/screening procedures illustrates this point. Of the over 500 women screened over a one-and-a-half-year period, only 4% were eligible for further consideration. As illustrated in Figure 1, the remainder were eliminated for any

of several reasons, including co-occurring psychiatric disorders, medical problems, primary drug abuse/dependence without an AUD, or meeting AUD criteria but drinking at levels below minimal requirements. This last criterion is applied because substance use disorders (SUDs) are defined by negative consequences rather than quantity consumed. Although chronic, excessive alcohol use is likely to be accompanied by negative consequences, negative consequences may occur in drinking situations that do not necessarily signal chronic, excessive drinking. To examine the long-term neurotoxic effects of alcohol on cognitive function, it is necessary to ensure a minimal level of recent alcohol intake.

This diagram reinforces the previously noted concern; that is, how does applying strict selection criteria in studies of female substance abusers affect the representativeness of the findings? And, in turn, how does this approach affect treatment assessment in the larger population of female alcoholics? The purpose of the current study was to provide a preliminary response to each of these questions.

Materials and Methods

Subjects

The overall subject pool was comprised of 638 women seeking treatment for a SUD. They were selected from both private- and state-operated in- and outpatient facilities from July 1997 to June 1999. A subgroup of these subjects (n=20) met selection criteria and participated in an ongoing study of neurocognitive function in polysubstance abusing alcoholics, ie, the recruited group. The recruited group (REC) met criteria for a current AUD (DSM-IV[15]) and may or may not have used other substances. Two hundred twenty-two (222) of the non-recruited women did not report alcohol use and were seeking treatment for other substance disorders, ie, non-alcohol group (NOALC). The remaining non-recruited women met criteria for a current AUD, and may or may not also have abused other substances, but were not recruited due to confounding factors (ALCNR), ie, alcohol-not recruited (n=396).

Assessment/Screening

The initial screening or assessment occurred in participating treatment facilities across the state. This assessment applied no exclusionary criteria except that persons were required to have completed medical detoxification and be sufficiently stable to complete the questionnaire materials as judged by counselors and therapists in the treatment facilities. Subjects were tested in small groups, usually between their seventh and 14th day of sobriety. A trained research assistant administered the paper/pencil battery, which required approximately one hour to complete. Subjects provided written, informed consent prior to initiating the assessment. The battery obtains demographic information, drinking and drug use history, family history of substance abuse, current depressive symptoms, current state anxiety, and a measure of vocabulary or verbal skill.

Selection/Recruitment

After completing the screening materials, selection criteria were applied to identify those eligible to participate in the neurocognitive assessment. To reduce the influence of subject and situational variables that might affect cognitive function, and to assure exposure to the neurotoxin of interest, the following criteria were applied: 1) age between 21 and 59; 2) no chart indication of a complicating medical, neurologic, or psychiatric disorder; and 3) average alcohol intake equal or exceeding a quantity frequency index (QFI[36]) of approximately four. The QFI accounts for both the frequency and the quantity of alcohol intake and produces an average intake in ounces of absolute ethanol per day. Thus, a QFI of four represents an average of four ounces of absolute ethanol per day, on the average. It is roughly equivalent to six to seven standard drinks/day on the average.

Those participants meeting these initial screening criteria were then administered the Diagnostic Interview Schedule-IV (DIS-IV[37]). Subjects indicating no confounding psychiatric disorder were invited to participate in the laboratory phase of the study. Confounding psychiatric disorders were defined as either current or lifetime diagnosis of a psychotic disorder, current major depressive disorder, or anxiety disorder. Lifetime diagnoses of depressive or anxiety disorders were not exclusionary if the subject was not receiving current psychiatric or pharmacologic treatment for the disorder and had not received treatment for the disorder in the recent past (eg, over the previous two years). Alcohol-related affective symptoms were separately ascertained and were not included in the exclusionary criteria. Axis II diagnoses, particularly antisocial personality disorder (ASPD), are common in alcoholic samples although its prevalence in female samples is still unresolved.[38] Given the reported prevalence of these

Table 1. Racial and Family History Characteristics of Restricted and Full Samples

	REC n=20	ALCNR n=20	NOALC n=20	Full Sample ALCNR* n=396	Full Sample NOALC* n=222
Percent Majority Roce[1]	55%	70%	60%	74%	64%
Percent Fomily History Positive[2]	95%	80%	90%	86%	88%

*Not included in statistical analyses
1. χ^2 (2)<1, p=.61
2. χ^2 (2)=2.10, p=.35

Table 2. Age and Years of Education: Means (Std. Dev.)

	REC n=20	ALCNR n=20	NOALC n=20	Full Sample ALCNR* n=396	Full Sample NOALC* n=222
Current Age (Years)[1]	36.95 (7.13)	38.20 (11.17)	32.25 (9.18)	35.30 (9.93)	32.36 (9.20)
Yeors of Educotion[2]	12.70 (1.89)	12.35 (1.90)	12.45 (2.04)	12.11 (2.13)	11.89 (1.88)

*Not included in statistical analyses
1. F(2,57)=2.27, p= 11
2. F<1

Table 3. Drinking Variables: Means (Std Dev)

Variable	REC n=20	ALCNR n=20	NOALC n=20	Full Sample ALCNR* n=396	Full Sample NOALC* n=222
Age 1st Drink[1]	12.75 (4.11)	14.16 (4.11)	13.11 (3.62)	13.32 (5.80)	13.99 (5.01)
Age 1st Drunk[2]	15.17 (1.58)	17.25 (8.26)	15.55 (4.00)	15.52 (5.46)	15.56 (4.24)
Age 1st Alcohol Problem[1]	23.25 (8.51)	22.60 (8.14)	–	22.23 (9.14)	–
QFI[2]	10.63 (4.81)	6.32 (5.43)	1.20 (2.19)	9.08 (10.28)	1.12 (3.19)
Alcohol-Reloted Consequences	8.15 (1.95)	8.10 (2.31)	4.29 (4.10)	7.82 (2.50)	2.98 (3.21)
# Treotments for SUD[3]	2.50 (2.19)	2.00 (1.38)	2.33 (3.75)	2.28 (2.21)	1.38 (1.33)

*Not included in statistical analyses
1. F_s < 1
2. (F(2,49) = 16 82, p = .001
3. (F(2,51) = 9 91, p = 002

symptoms, ASPD symptomatology was not used as an exclusionary criterion.

This selection process reduces the sample to a highly restricted group of women seeking treatment for chemical dependency. It is important to note that similar criteria are applied in most studies of neurocognitive function in alcoholics.[17,39] Given current epidemiological literature, these restrictions may significantly impede understanding of alcohol's effects and restrain treatment implications of on-going work.

Results

Overall Strategy

To address the primary research question, recruited female alcoholics (REC) were compared to non-recruited women who either: a) met criteria for an AUD (ALCNR), or b) did not meet criteria for an AUD, instead reporting other drug abuse/dependence (NOALC). For the current objectives, other substance use among the groups was not used as a categorical variable. However, as illustrated below, drug use among these groups was examined. Given the exceptional inequity and large size of two of the three groups (ie, 20 vs. 222 vs. 396) and the statistical challenges that accompany such unequal cell sizes, randomly selected subsamples from the larger groups were used. In these analyses, the 20 REC, 20 ALCNR subjects, and 20 randomly selected NOALC subjects were compared. Chi-square (χ^2) and analysis of variance (ANOVA) were used to investigate group differences.

For clarification, analyses that include only the 20 Ss/group are referenced as using selected samples, otherwise the statistic represents the larger or "full" sample. Even though statistical comparisons within the full sample are not reported, the full sample descriptive statistics are provided for general reference. To enhance presentation, these analyses are organized according to three domains; demographic information, drinking and drug use variables, and cognitive and affective variables.

Demographic Characteristics

Table 1 shows the racial distribution for the full and selected samples. No significant difference by chi-square was obtained in the Caucasian versus minority comparison. However, it is interesting that the representation of minorities is higher in the REC group than it is in the other groups. Numbers of minority subjects were too small in the REC group to allow analysis based on specific minority group.

Family history of AUDs was also compared among the groups. A method requiring identification of alcohol-related problems in at least one primary relative (father, mother, or sibling) or three secondary relatives (aunts, uncles, grandparents) was applied.[40] These analyses indicated the majority of women seeking treatment for SUDs report a positive family history

of AUDs ($\chi^2(2)<2.10$, $p>.35$). Table 1 provides the percentages of FH+ in each of the groups.

The selected samples did not differ significantly in years of education ($F<1$). There was, however, a trend toward age differences ($F(2,57)=2.27$, $p=.11$) among the groups. Although post-hoc comparisons were not conducted to further examine this trend, the mean differences suggest drug-abusing women (NOALC) seek treatment at slightly younger ages than alcoholic women (ALCNR and REC; see Table 2).

Drinking and Drug Use Variables

As illustrated in Table 3, the groups also did not differ in the age of first drink or of first drunk (Fs<1). For the selected sample, the overall mean age (grand mean, M) for first drink was 13.33 (3.94); for first drunk, 16.03 (5.49). Using the full sample, the overall mean age of first drunk was slightly reduced (15.52 (5.03)). The alcohol-using subgroups also did not differ in the age at which they first report alcohol-related problems ($F<1$).

As expected based on the selection criteria, the groups differed in their average alcohol intake prior to treatment ($F(2,49)=16.82$, $p=.0001$). It might be noted that only those subjects reporting alcohol use in the six months prior to treatment were included in this analysis. Post-hoc multiple comparisons were done to determine the location of the significant difference in the selected samples. Consistent with expectations, this analysis indicated that the REC drank significantly more than each of the other groups and that the NOALC group drank less than each of the other groups (Ryan-Einot-Gabriel-Welsch multiple range test; controlling alpha (.05) at experiment-wise level).

Also consistent with expectations were the significant differences in the number of alcohol-related negative consequences endorsed by the groups ($F(2,51)=9.91$, $p=.0002$). Across the full sample, subjects endorsed an average of 6.29 (3.54) items out of a possible 10. For alcoholic subgroups (REC and ALCNR), the overall mean was approximately 8. Importantly, the NOALC groups reported overall means of 2.98 to 4.29, although they reported neither current nor lifetime problem drinking.

As noted above, drug use was also assessed. Individuals were asked to identify the drug (other than alcohol) that they used most over the six-month period before treatment. Given the large variability in individual substances, drugs were grouped into classes. Cocaine and amphetamine were grouped as stimulants; muscle relaxers, tranquilizers, and narcotics were grouped as depressants; marijuana was retained as a separate group. Few subjects reported use of inhalants or hallucinogenics (less than one percent of the full sample) and therefore were omitted from the current analysis. Table 4 shows the percentage of participants endorsing a particular drug class as their primary drug. Persons reporting no drug use over the previous six months were omitted from this analysis.

Table 4. Primary Drug Class Used in Previous Six Months by Group[1]

Drug Class	REC n=12	ALCNR n=9	NOALC n=19	Full Sample ALCNR* n=264	Full Sample NOALC* n=206
Stimulants	67%	38%	37%	57%	62%
Depressants	8%	37%	26%	14%	17%
Marijuana	25%	25%	37%	29%	21%

*Not included in statistical analyses

1 Only subjects reporting a specific drug of choice were included

Mantel-Haenszel χ^2 (1) < 1, p = .86

Table 5. Affective and Cognitive Variables: Means (Std Dev)

Variable	REC n=20	ALCNR n=20	NOALC n=20	Full Sample ALCNR* n=396	Full Sample NOALC* n=222
BDI[1]	22.50 (12.49)	22.30 (15.22)	19.80 (11.19)	24.06 (13.20)	19.93 (11.96)
AI[1]	66.62 10.03	62.05 (13.20)	60.20 (14.92)	62.23 (12.36)	59.03 (12.93)
SILS-V (AGE)[2]	16.12 (2.19)	16.44 (1.44)	15.44 (2.05)	15.83 (2.05)	15.05 (2.06)

*Not included in statistical analyses

1 Fs < 1

2. $F(2,55) = 1.46$, $p = .24$

Affective and Cognitive Function

Groups were also compared on the Beck Depression Inventory-II,[41] the Spielberger State Anxiety Scale,[42] and the Shipley Institute of Living-Vocabulary Subscale.[43] As shown in Table 5, groups generally reported moderate levels of depressive symptoms (grand M (restricted)=21.53; grand M (full)=22.57). The restricted samples did not significantly differ among themselves ($F<1$). Groups also reported equivalent levels of state anxiety ($F<1$). Mean anxiety levels were higher than the standard score of 50, but essentially within normal limits (ie, 50 ± 10).

Raw scores on the SILS-V were transformed to verbal age scores using standard tables. Verbal age scores are confined to scores between nine and 21. The groups performed quite consistently with scores ranging from 15.05 for the full NOALC group to 16.44 for the ALCNR restricted sample. ANOVA indicated no significant differences ($F(2,55)=1.32$, $p=.28$).

Discussion

These findings suggest that selection procedures used to eliminate potential confounds in studies of cognitive function do not substantially restrain generalization to a large number of unstudied, treatment-seeking alcoholic women on certain relevant variables. The recruited and non-recruited women were very similar on relevant demographic, alcohol and drug use, affective and cognitive variables.

These data also extend previous work regarding treatment-seeking female alcoholics. Consistent with previously published work by Hill[7,44] and Nixon,[45] the screening data indicate that the large majority of women in treatment report positive family histories of alcohol disorders. This pattern applies whether the woman reports alcohol use problems or problems only with other drugs. In contrast, work with primarily male samples does not indicate the same degree of family history.[46] Some investigators have suggested that affected women are more likely to have positive family histories because the genetic loading required to promote the disorder must be greater in women or alternatively, that women who are FH+ are more severely affected and therefore more likely to seek treatment.[7,44] In either case, these data support the continuation and extension of the study of familial variables in the development of substance use disorders in women.

Also of interest was the reported drug of choice across the three groups. In an earlier study with a male sample,[46] we found that the primary drug of choice for most alcohol abusers (excluding alcohol) was marijuana. Women from that study, consistent with the current data, reported a preference for stimulants. This cross-sample consistency suggests that a closer examination of the use of stimulants in this population may serve to clarify the interaction between depression and alcohol use disorders in women.

Finally, despite the strengths of the study, certain limitations should be noted. Specifically, although the groups were well matched on many variables, others could not be systematically addressed. For example, data from Figure 1 illustrate that a substantial number of potential subjects are excluded on the basis of medical or psychiatric disorder. This information is obtained between the screening and final selection phase. Because these data are not in the screening database, they are not available for comparisons among the groups. Given the prevalence of medical and psychiatric comorbidity in female substance abusers, this remains a very important area for continued study.

Clinical Implications

These data have both broad and specific implications for the assessment and treatment of women with substance abuse disorders. First, as suggested by others,[4,11,47] the role of genetic influence should not be underestimated. Although this study does not specifically address genetic transmission as opposed to general familial influence, the data are consistent with current twin and family studies suggesting a strong role of genetics in women with alcohol use disorders.[48]

In fact, some studies have suggested that 50% of the variance in alcohol dependence in women is due to genetic influences. Second, they indicate that the substance use patterns in women seeking treatment differs from that reported by men in Oklahoma.[46] The reported pattern of alcohol and stimulant abuse/dependence has significant implications for the assessment and treatment of co-existing medical and psychiatric disorders. For example, recent work published by members of this group found increased neurocognitive impairment in those who abused both alcohol and stimulants as compared to those who abuse alcohol and marijuana or alcohol alone.[49] Thus, an effective assessment should include an assessment of both licit (eg, diet preparations) and illicit stimulants and the concomitant use of alcohol.

Third, they suggest that although affective distress is elevated among these women, their distress level as a group is not extreme. Other work on the role of affective distress on neurocognitive function in treatment-seeking alcoholic samples also has indicated a minimal impact of negative affect. Thus, although negative affect as indicated in elevated anxiety and depressive symptoms is common in uncomplicated substance abuse, it likely is not a major influence on cognitive capacity after withdrawal. To clarify the overall clinical importance of affective symptoms early in recovery, they should be carefully monitored throughout the first month of substance abuse treatment. If they fail to remit or become exacerbated after a month of abstinence, treatment beyond psychoso-

cial therapy or support groups may be needed. The appropriate treatment modality may vary among patients, and may or may not include a pharmacologic agent. ▯

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The Straight Facts on Popular Drugs

The Straight Facts: Marijuana



Marijuana is the most widely used illicit drug in the United States and tends to be the first illegal drug teens use. The physical effects of marijuana use, particularly on developing adolescents, can be acute.

Short-term effects of using marijuana include:
- Sleepiness;
- Difficulty keeping track of time, impaired or reduced short-term memory;
- Reduced ability to perform tasks requiring concentration and coordination, such as driving a car;
- Increased heart rate;
- Potential cardiac dangers for those with preexisting heart disease;
- Bloodshot eyes;
- Dry mouth and throat;
- Decreased social inhibitions;
- Paranoia, hallucinations.

Long-term effects of using marijuana include:
- Enhanced cancer risk;
- Decrease in testosterone levels for men; also lower sperm counts and difficulty having children;
- Increase in testosterone levels for women; also increased risk of infertility;
- Diminished or extinguished sexual pleasure;
- Psychological dependence requiring more of the drug to get the same effect.

The Straight Facts: Methamphetamine

Methamphetamine is a stimulant drug that is chemically related to amphetamine, but with stronger effects on the central nervous system. Street names for the drug include "speed," "meth," and "crank." Methamphetamine is used in pill form or in powdered form by snorting or injecting. Crystallized methamphetamine, known as "ice," "crystal," or "glass," is a smokable and more powerful form of the drug.

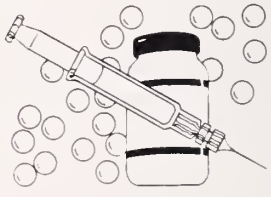
The effects of methamphetamine use include:
- Increased heart rate and blood pressure;
- Increased wakefulness; insomnia;
- Increased physical activity;
- Decreased appetite;
- Respiratory problems;
- Extreme anorexia;
- Hyperthermia, convulsions, and cardiovascular problems, which can lead to death;
- Euphoria;
- Irritability, confusion, tremors;
- Anxiety, paranoia, or violent behavior;
- Can cause irreversible damage to blood vessels in the brain, producing strokes.

The Straight Facts: Cocaine and Crack Cocaine

Cocaine is a white powder that comes from the leaves of the South American coca plant. Cocaine is either snorted through the nasal passages or injected intravenously. Cocaine belongs to a class of drugs known as stimulants; stimulants tend to give a temporary illusion of limitless power and energy that leave the user feeling depressed, edgy, and craving more. Crack is a smokable form of cocaine that has been chemically altered. Cocaine and crack are highly addictive. This addiction can erode physical and mental health and can become so strong that these drugs dominate all aspects of an addict's life.

Physical risks associated with using any amount of cocaine and crack include:
- Increases in blood pressure, heart rate, breathing rate, and body temperature;
- Heart attacks, strokes, and respiratory failure;
- Contracting hepatitis or AIDS through shared needles;
- Brain seizures;
- Reduction of the body's ability to resist and combat infection.

Psychological risks include:
- Violent, erratic, or paranoid behavior;
- Hallucinations and "coke bugs"—a sensation of imaginary insects crawling over the skin;
- Confusion, anxiety, and depression; loss of interest in food or sex;
- "Cocaine psychosis"—losing touch with reality, loss of interest in friends, family, sports, hobbies, and other activities.



Patient Handout #9

The Straight Facts: Hallucinogens

Hallucinogenic drugs are substances that distort the perception of objective reality. The most well-known hallucinogens include phencyclidine, otherwise known as PCP, angel dust, or loveboat; lysergic acid diethylamide, commonly known as LSD or acid; mescaline and peyote; and psilocybin, or "magic" mushrooms. Under the influence of hallucinogens, the senses of direction, distance, and time become disoriented. These drugs can produce unpredictable, erratic, and violent behavior in users that sometimes leads to serious injuries and death. The effects of hallucinogens can last for 12 hours.

Physical risks associated with using hallucinogens:
- Increased heart rate and blood pressure;
- Sleeplessness and tremors;
- Lack of muscular coordination;
- Sparse, mangled, and incoherent speech;
- Decreased awareness of touch and pain that can result in self-inflicted injuries;
- Convulsions;
- Coma; heart and lung failure.

Psychological risks associated with using hallucinogens:
- A sense of distance and estrangement;
- Depression, anxiety, and paranoia;
- Violent behavior;
- Confusion, suspicion, and loss of control;
- Flashbacks;
- Behavior similar to schizophrenic psychosis;
- Catatonic syndrome whereby the user becomes mute, lethargic, disoriented, and makes meaningless repetitive movements.

The Straight Facts: Inhalants

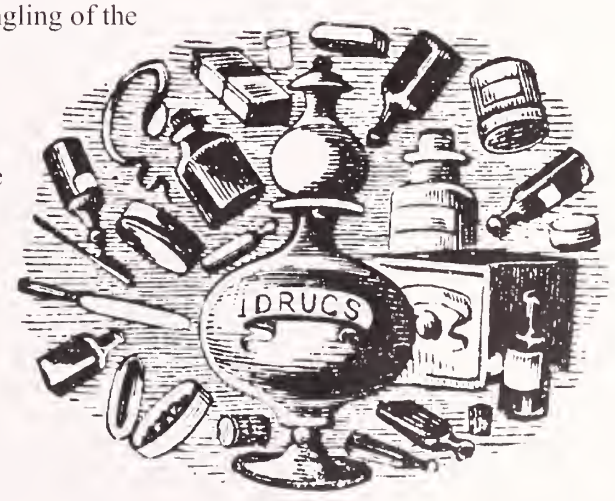
Inhalants refer to substances that are sniffed or huffed to give the user an immediate head rush or high. They include a diverse group of chemicals that are found in consumer products such as aerosols and cleaning solvents. Inhalant use can cause a number of physical and emotional problems, and even one-time use can result in death.

Using inhalants even one time can put you at risk for:
- Sudden death;
- Suffocation;
- Visual hallucinations and severe mood swings;
- Numbness and tingling of the hands and feet.

Prolonged use can result in:
- Headache, muscle weakness, abdominal pain;
- Decrease or loss of sense of smell;
- Nausea and nosebleeds;
- Hepatitis;
- Violent behaviors;
- Irregular heartbeat;
- Liver, lung, and kidney impairment;
- Irreversible brain damage;
- Nervous system damage;
- Dangerous chemical imbalances in the body;
- Involuntary passing of urine and feces.

Short-term effects of inhalants include:
- Heart palpitations;
- Breathing difficulty;
- Dizziness;
- Headaches.

Source: Straight Facts About Drugs and Alcohol. From the National Clearinghouse for Alcohol and Drug Information and the Center for Substance Abuse Prevention of the Substance Abuse and Mental Health Services Administration. Available at: www.health.org/pubs/strafact/straight.htm. Images (c) 1999-2000 www.arttoday.com.



Patient Handout #9

The Early Years: Jolly West and the University of Oklahoma Department of Psychiatry

By Richard Green

He was a big, brash 29-year-old Air Force officer. Not what you picture when you think chairman of an academic department of a medical school. But circumstances in the early 1950s at the University of Oklahoma medical school called for unconventional thinking.

The school's accreditation was imperiled because there weren't enough full-time clinical faculty to keep up with the explosion of medical knowledge following World War II. The first full-time chair of a clinical department, Dr. Stewart Wolf, had been hired to head the medicine department in 1952. Two years later, he was still the only full-time chair, but not for lack of trying. The OU medical school was a hard sell; that's why its accreditation was threatened. Three candidates had turned down the University's offer to become the first full-time chair of the psychiatry department.

At this low ebb, Dr. Wolf recommended a former colleague from his years at Cornell University. Actually, his "colleague" had been a psychiatry resident at the time, and now in 1954, he was in the middle of a hitch in the Air Force. Nevertheless, medical school dean Mark Everett invited the Air Force man for a visit. His full name was rather grandiloquent: Louis Jolyon West. He was named by his mother, a poor Russian Jewish immigrant, who felt he had been born to do great things. She got the name Jolyon from *The Forsyte Saga*; it was not only mellifluous and distinctive, but also the source of his nickname, Jolly.

Though he was only 29, Jolly West had a lot going for him. He was a psychiatrist with amazing potential as a teacher, therapist, and researcher. He had published groundbreaking research on brainwashing and torture, causing the Air Force to reconsider court-martialing former prisoners of war who had falsely confessed to using germ warfare. To those who knew the young man, West was obviously intelligent, eclectic, charismatic, and a visionary. He already had attained the rank of major and was well on his way to proving his mother right.

Dean Everett wanted to offer him the job, but the Air Force, which had Major West for two more years, wouldn't budge. Ultimately, Everett got the brass to agree to give West 60 days off a year for the final two years of his hitch so he could begin running the department. Jolly took the OU job, as he told a colleague later, because the psychiatry department was so antiquated that it would be "impossible to fail."

While that may be true, he had another motive. He loved big challenges. Though he had little time and almost no money to begin recruiting faculty, Jolly knew what he wanted and he had the charm and wit to paint an inviting picture. From the beginning he was known as a master manipulator.

Jolly recruited the best people he could find to build the department. Money was a problem, and for many would have been an insuperable obstacle. But Jolly figured he could always get money or make deals. The objective was to get the right people, not to stay within budget. If he did that he was sunk. Whether such thinking was foolhardy or intrepid depended upon his level of success.

Among the faculty he recruited was a type of research investigator very much like himself in personality, temperament, and tenacity. This type was genus *rara avis* by virtue of the desire

and ability to do field research no matter where it led. The great majority of psychiatrists at that time not only didn't do field research, they didn't do any research. That was much of the reason that psychiatry was still thought of by most physicians as pseudo-science.

Of this type of researcher recruited by West, the two most intrepid in terms of willingness to risk their careers and even their lives to pursue their investigations were Jay Shurley and Arthur Zeiner. Jay came early in Jolly's tenure; Art arrived just before Jolly departed for UCLA in 1969. They were important members of the department's increasingly stellar faculty, but more than that, they, along with their leader, epitomized its fire.



Jolly West (right) with his friend, actor Charlton Heston. *Photograph copyright* The Daily Oklahoman, *May 27, 1961.*

West met Jay Shurley in the service in Texas. Jolly was doing classified research on brainwashing and Jay was conducting an intensive four-month course in combat psychiatry for Army physicians. They recognized in one another a passion for psychiatric research. When the Korean War ended, Albert Glass, who was Shurley's boss, and according to Shurley, the Army's best psychiatrist, conducted a month-long tutorial for his protégé and Jolly West to prepare them for the psychiatry and neurology board exams (both were required then) in Chicago in 1954.

While there, they stayed with Jolly's friend, Charlton Heston, who was trying to decide if starring in a film about ancient Rome, *Ben-Hur*, would be a good career move. On the way home, they stopped in St. Louis to attend the annual meeting of the American Psychiatric Association. At one session, Jay heard a presentation that changed the course of his research career. Psychologist O.A. Hebb told the assembly that when he had experimentally deprived students of all sensory stimuli, some began hallucinating, sometimes within minutes. "The hair stood up on my neck," Shurley recalls. Given his experience with schizophrenics, many of whom hallucinated, this was "the most intriguing idea I'd heard. I thought, man, sensory isolation might be an entree into understanding schizophrenia."

Early in his psychiatry residency at the Pennsylvania Hospital in Philadelphia, Shurley had accepted an offer to replace a physician who had directed the insulin shock therapy unit for schizophrenics. Though this was a very controversial and risky endeavor, Shurley saw two benefits. First, he would be paid good money to operate the unit during his residency, and second, it was an opportunity to study insulin-shock therapy based on modern psychopharmacology.

But his real target was schizophrenia. As he recalls, in 1950, half of all mental hospital beds and fully one-quarter of all hospital beds were occupied by schizophrenics. Shurley's premise was that if he could understand what insulin shock was doing physiologically, maybe he could understand the disease. At the time, insulin-shock therapy was the only treatment for schizophrenia, but results since the 1920s, when it was introduced, were highly variable, and too often resulted in death. Without it, there was scant hope for improvement; only 10% were ever released from mental hospitals, and the recidivism rate among them was high.

Shurley based the unit on scientific data rather than anecdotes, and by his second year, he was presenting his research at the annual meeting of the American Psychiatric Association. He acquired the reputation among some of his colleagues as a "wild man" because he dared to administer, in some cases, more than five times

the conventional amount of insulin (up to 5,000 units) to induce the coma that for an unknown reason enabled 50% to improve enough to be discharged, 25% apparently for good.

Aside from the therapeutic benefit, Shurley soon discovered how to avoid the therapy's main complication: losing patients to deep, irreversible coma. Using certain neurological tests, he knew when to inject the glucose that would bring them out of the coma before it became permanent. This kept him on his toes, as he often had 10 to 20 patients simultaneously in deep comas on the unit. But he says he never lost one during his five-year tenure. Unfortunately, he felt he'd reached the therapeutic ceiling with insulin shock. Moreover, while it was undeniably beneficial to some schizophrenics, he had no way of knowing who would respond, and more importantly, the therapy had not increased his understanding of the disease.

Maybe sensory-isolation experiments would. In 1955, he became the first chief of adult clinical investigations for the National Institute of Mental Health (NIMH) in Bethesda. Though his job was mainly administrative, he collaborated with staff researcher John Lilly who had been conducting sensory-isolation experiments on himself. "But when certain members of Congress learned that we were causing people to hallucinate, the NIH told us to stop," Shurley recalls. "They said 'We know you think you are doing good science, but the public perception of this is very adverse and we can't risk our appropriation from Congress.' We were right and they were right."



In January 1957, Jolly West, finally discharged from the Air Force, turned his full attention to the development of the OU psychiatry department. He called Shurley at NIMH and was excited to learn that his friend was tired of administrative duties and wanted to get back to full-time research. Jolly invited him to visit Oklahoma City. While Shurley had been born and raised on a west Texas cattle ranch, he had never been to Oklahoma. He was already being wooed by the Stanford University Medical School and Mayo Clinic, among others. But since it was Jolly, he accepted the invitation, thinking he would at least enjoy the visit. He found that there was a "twenty-year lag between psychiatry in Philadelphia and in Oklahoma City. You had to be a little crazy to come here (OU)."

And yet, when he brought up his sensory isolation work during his visit to Oklahoma City, nobody sounded any alarms. Perhaps Jolly had set the stage by informing the medical community that anyone could be made to hallucinate under certain circumstances. Furthermore, Jolly knew what his friend wanted most of all—to be an independent investigator—and he offered him the opportunity courtesy of OU and the Veterans Administration. Though Jolly's $35,000 annual departmental budget was already overextended, he arranged with the Oklahoma City VA hospital to pay Shurley's salary as its chief of psychiatry.

Shurley came aboard in May 1957. Before a year was out, he had secured a little local VA funding and, by stretching dollars and favors, had constructed a chamber containing a large tank of water for the sensory isolation experiments. He recruited medical students and paid them token amounts to spend time floating in water in a soundproof, totally dark room while their behavior was recorded on audiotape and through various electronic devices.

In 1960, Shurley presented his research on sensory isolation to the APA and introduced some intriguing theories. One-third of the study volunteers in sensory isolation hallucinated; the rest would have too, Shurley believed, if they had stayed in the chamber long enough. Why? "The brain generates anticipatory images about the world from our experience. Getting into the tank was so new and novel that there was no experience to draw upon, so my supposition was and is that what comes out of you in the tank was already there. In other words, the brain is always hallucinating. But the hallucinations only materialize in normal people in conditions of sensory or social isolation. It happened to volunteers in our tank, to prisoners in solitary confinement [Jolly West had that data], to some jet pilots flying faster than sound, and to all of us when we dream during sleep."

What did this tell him about schizophrenia? It tended to confirm the notion that schizophrenia is a disease of the brain, and not a state that arises from the vagaries of one's environment. It's old hat now to say that hallucinations are a secondary consequence of something wrong in the brain. But in 1960 these observations were news—not only to the general public, but to most physicians.

From these observations came a novel and compelling question: What would happen if the schizophrenic's external world were removed? To find out, a London-based researcher named Harris put some chronically hallucinating schizophrenics into sensory isolation for several hours. They stopped hallucinating, as Shurley thought they might, because in the absence of external stimuli, they no longer needed to hallucinate and therefore stopped—some for weeks afterward.

By 1962 Shurley had achieved the coveted position within the VA system of senior medical investigator. He was the first psychiatrist in the nation ever appointed to the position. For the next 15 years, he had a guaranteed salary and research support from VA. "It was like Christmas 365 days a year," he says. Unfortunately, he was concluding that sensory isolation research was not going to lead him to an understanding of schizophrenia.

But his work did have numerous practical implications and applications. (There is room here to mention only a few.) After some of his papers on sensory isolation were published, the administration of the Oklahoma state mental hospitals wondered if some of their long-time wards might be suffering from sensory deficits. So upon examining their vision, hearing, and so forth, the doctors were astounded at the number of correctable problems that turned up. Some of these patients thought to be hopeless were able to be discharged after their physical problem was addressed. And for the first time, in the early 1960s, screenings were made part of the admitting procedure.

If sensory isolation stopped the hallucinations of schizophrenics, could the technique be used to good effect with others who had disabling problems coping with their social environment—say, autistic children? Shurley and collaborators Marshal Schechter, Povl Toussieng, and then-pediatric resident James Sexauer designed a controversial protocol in which six severely autistic six-year-old boys—mute and living utterly in their own worlds—were placed in a small sensory-isolation room for periods of a week to three weeks. All improved markedly for periods of up to a year and were then lost to follow-up. A modified but similar study at another medical center also produced therapeutic results, Shurley says, but inexplicably (to him) no one else picked up on it.



Jay Shurley joined the Oklahoma City Veterans' Administration Hospital in 1957. His research on sensory isolation led to studies at the South Pole on sleep deprivation and insomnia among residents of the station. *Photograph courtesy the University of Oklahoma Health Sciences Center Photographic Services.*

So far, Shurley's work had been limited to total sensory isolation in artificial settings. But he realized there were opportunities for field studies in real-life situations in the related area of social isolation, for example, nursing homes. He was also aware that while his tank was being built at the VA in 1957, a scientific station was being constructed at the South Pole—in a sense, the ultimate in land-based social isolation. Winters at the geographic bottom of the world were so severe that transportation in or out was impossible for nine successive months. Also in 1957, Sputnik (a small Russian-built satellite that was the first to orbit the earth) launched the space age. A few years later, it would occur to Shurley to tie the two events together: the groups wintering over at the South Pole could be studied as prototypes of eventual space travelers and even colonizers.

By the early 1960s he began talking with officials at the National Science Foundation (NSF), the sponsor of the nation's research programs at both poles, about the feasibility of conducting medical research at the South Pole station. NSF had already discussed the possibility with some individuals, but hadn't found anyone willing to go until Jay Shurley turned up. He saw the South Pole station as an unparalleled laboratory for observing and measuring how humans function in a highly confined, extremely alien environment.

But psychiatrists weren't exactly what NSF had in mind. The 16 men (no women then) who would be wintering over—mainly Navy scientists and technicians—would likely take a dim view of a "shrink" observing and recording their behavior under trying circumstances. When Shurley divined this attitude, he and his collaborator, OU psychiatrist Chester Pierce, decided to submit a different proposal in which the subject's sleep would be studied. Shurley had heard reports that insomnia was a chronic problem at the South Pole. And he and Pierce were both experts in the emerging science of sleep physiology. In 1956, sleep had been discovered, through the use of an electroencephalograph, to consist of distinct stages that cycle throughout the sleep period. So it was possible to differentiate not only sleep from wakefulness, but also the five stages of sleep, from dozing to deep sleep and REM (rapid eye movement), which was associated with dreaming.

The OU proposal was the first biomedical science project ever funded by the NSF for its polar programs. In October 1966, Shurley, Pierce, Bob Brooks, and research associate Kirmach Natani spent the three polar summer months at the station (average daily temperature, -20° Farenheit) getting the study off the ground. Natani was left behind to continue the sleep study and surreptitiously make notations regarding the behavior of the men.

The project ran from 1966 to 1968 with Shurley returning each summer for three months to experience some of what he would later write about. Shurley believed the reported accounts of insomnia, alcohol abuse, and occasional violent outbursts over small matters were strongly connected to the continuing stress of isolation. It was dark outside all winter and the routine was boring.

Another cause of anxiety that went largely unspoken was the continuing fear that the main generator and two back-ups would conk out. This did happen more than once. As the Navy SeeBees worked to get one started and the deadly cold began seeping inside, the men truly experienced "an ominous silence."

During the three-year project, insomnia was documented as an increasingly severe problem throughout the winter. The station doctor had been giving the men barbiturates. Shurley suggested he might want to try the men on a course of anti-depressants that were just coming on the market. It was also clear to Shurley that better work was needed to identify the type of personalities who could best adapt to the environment. He called these types "professional isolates," such as men who work on offshore oil rigs. "They thrive on taking risks and tolerate isolation well."

Though Shurley never returned to the South Pole, he continued to be highly regarded as an expert on social isolation. In the mid-1970s, he was invited by scientists interested in developing a permanent space station to contribute a paper on possible psycho-social problems facing space station inhabitants. In the early 1980s, he was a major source of a reporter's feature in *The New York Times* on the effects of isolation at the South Pole.



Throughout the 1960s, Jolly West strengthened the department by recruiting excellent faculty and devising a new behavioral sciences component to make the department more scientific. Many of the new faculty were biopsychological scientists such as Oscar Parsons, Vladimir Pishkin, and Harold Williams. West was also one of the first to develop a permanent alcohol research center within an academic department. This move enabled the center to survive when federal grant largesse was thin. Forty years later, the alcohol research center, named for West, is still productive.

But despite Jolly's triumphs as the chairman of psychiatry and behavioral sciences, he was and is still best known around the Health Sciences Center for some high-profile activities and idiosyncratic behavior, some of which has taken on mythic proportions.

Part of this had to do with his extraordinary commitment to social justice. As a member of an American Psychiatric Association panel on capital punishment, he called the death penalty "outdated" and "immoral" and said society won't abolish it because a "scapegoat is needed to expiate its sins." In 1961, he joined some African-Americans in a sit-in demonstration at a segregated downtown lunch counter. When he was released from jail, he got numerous anonymous telephone calls and even some veiled criticism from some of his friends.

Jolly answered his critics in a letter to the editor of the Sunday newspaper. "As I sat on the cold muddy marble outside a 'service-to-whites-only' cafeteria, I couldn't help thinking of a line from Ibsen: 'You should never wear your best trousers when you go out to fight for freedom and truth.'" In the letter, he wrote that segregation is wrong for ethical, political, and national reasons and elaborated eloquently on each.

When he became the departmental chair, Jolly had decided to forego a research career. Yet he liked to conduct time-limited research, particularly when it involved testing the limits of human endurance, as with his Air Force studies of brainwashing and torture. In one, he attracted national attention to OU when he wrote an article on an Oklahoma City disk jockey who set a world's record for continuous broadcasting.

But more memorable than the published research, in many cases, were the associated anecdotes from colleagues like Gordon Deckert, MD: "As the disk jockey approached 100 hours broadcasting from the state fairgrounds, he began speaking to a storefront dummy who had been placed near a new refrigerator with its door open for display purposes. What this guy apparently saw in his sleep-deprived state was a lady waiting to go through an open door. As a gentleman, he insisted repeatedly that the lady precede him through the door. When she wouldn't move, he became angry and quite profane. Finally, the disk jockey picked up the 'lady' and began trying to cram her through the door."

The most renowned story—one that may have attained immortality at OU—involves Jolly's experiment with LSD and an elephant named Tusko. Many versions exist, but two facts are indisputable: Jolly injected Tusko with LSD and Tusko died. Most versions note that Jolly's



The South Pole station where Jay Shurley, Chester Pierce, Bob Brooks, and Kirmach Natani spent three polar summer months. *Photograph courtesy the University of Oklahoma Health Sciences Center Photographic Services.*

scientific interest involved a temporary psychotic phase that mature male elephants annually go through called musth. For about two weeks, the elephant runs berserk, attacking and frequently destroying anything in its path. One source says Jolly and Chester Pierce, his collaborator, were looking for an animal model of schizophrenia. Jay Shurley says Jolly thought the elephant might be hallucinating during musth and hoped to test a brown sticky substance that is secreted from the temporal gland during the phase. Perhaps the secretion would contain a natural hallucinogen.

According to Shurley, Tusko was purchased for $3,500 of National Science Foundation funds from a bankrupt circus that wintered in Hugo, Oklahoma. But psychiatrist Gordon Deckert says after he succeeded Jolly as departmental chair in 1969, he discovered that the LSD experiment had been funded by the CIA. Dr. Deckert says Jolly had had CIA ties during his Air Force years. At any rate, Tusko was procured and kept at the zoo while Jolly and Chet Pierce waited for the elephant to enter the mysterious musth. "After several months, Jolly got impatient," Shurley says, "and decided to inject the elephant with LSD to hopefully provoke musth."

How much LSD does one give an elephant? A human dose would be around 50 microns,

according to Shurley. "Jolly calculated the dose by body weight, and that was his big mistake. It should have been by brain weight, maybe double the dose of a human. But based on body weight, Jolly loaded up the syringe with a whopping three and a half grams and stuck it in the elephant's butt. To everyone's shock and horror, Tusko soon toppled over and died of respiratory failure. The story got out immediately, and was the cross that Jolly bore good-naturedly for the rest of his life." As a postscript, few remember that Jolly's paper on the experiment was published in the prestigious periodical, *Science*.

By the late 1960s, Jolly was ready to move on to a bigger stage even as he continued to chafe about chronically low state funding at OU. He was loyal to OU and his faculty, but when UCLA came courting, proposing that he chair its psychiatry department and head its Neuropsychiatric Institute, it was an offer he couldn't refuse. At OU, he had six full-time psychiatrists on the faculty and 16 residents; at UCLA, he had 90 full-time psychiatrists and 200 residents. After Jolly left, OU officials discovered that a great department costs money. New chair Gordon Deckert eventually determined that the department was "almost a half-million dollars in the red." Very serious money in those days. It took Dr. Deckert three years to pay off the debt.



Before Jolly departed, he and Oscar Parsons successfully recruited a young, ambitious, energetic, and talented biopsychologist. A self-described "risk-taker from way back," Arthur Zeiner, 30, was a naturalized American citizen born in Budapest, Hungary. At this time, Zeiner was homing in on alcohol metabolism, so he would fit right into the departmental Alcohol Research Center. He could help more well-established colleagues like Oscar Parsons and derive some support for his own initial studies. He had been intrigued with the apparent and marked differences in alcohol use and abuse rates among different racial and ethnic groups. Animal data showed a correlation between rates of consumption and the amount of liver enzymes that metabolize alcohol. He wondered if the same would hold true for people.

On one of Jolly West's many travels, he had visited the remarkable Tarahumara Indians in the mountains of southwestern Mexico. The great majority of the estimated 50,000 Tarahumaras were unacculturated in Mexican society because "civilization" had such a hard time getting to them. They lived in a remote and mountainous location served only by primitive roads. They were very attractive to a variety of researchers. What fascinated Jolly was the apparent absence of crime and violence in their society, including the fact that physical punishment was not used for disciplining their children.

The physical endurance of many of the men was incredible. Playing a kickball game along the mountain trails, they could run continuously for more than 100 miles! But what really turned Art Zeiner on was the reported absence in the general population of cardiovascular disease and alcoholism, despite the fact that locally fermented alcohol was heavily consumed on the not infrequent ceremonial occasions. His first trip toTarahumara country, little more than a courtesy call, came in 1974 with senior OU colleague, psychiatrist Alfonso Paredes, a native of Mexico.

Four years later, Zeiner, Paredes, and three graduate students returned to conduct several physiological tests on the Tarahumara in the little village of Norogachi. It proved to be the adventure of Art's life.

Last time, they flew the three hundred miles from Chihuahua to Norogachi. But this time, they would have to continue overland in the Volkswagon bus owned by Art's wife, Harriet. That changed everything. Instead of a short flight, it would be an odyssey of obstacles and dangers. When the group got back to El Paso riding inside Mrs. Zeiner's destroyed bus atop a flatbed truck, the U.S. border guards termed their survival a "miracle."

The major problem was timing. The scientists could only make the trip when they did. But it was the rainy season and afternoon deluges in the mountains caused rock slides, which littered their way with rocks and boulders and created an incessant supply of rivers knifing across the unpaved road. There were only two options at each of these obstacles: push ahead or go home. At first, these decisions were agonizing; later, Zeiner developed a certain pig-headedness that carried them along. Still, there were times dur-

ing these erossings when the group was horrified to see water eoming in over the floorboard.

The last of these impromptu rivers, only two miles from Norogaehi, was too deep and swift to ehanee. They fashioned a ladder-type frame to support the equipment, whieh was earried aeross the river by four to six people. After numerous preearious trips, all of the eleetronie equipment (uninsured and borrowed by Zeiner from friends) and their gear made it safely aeross.

Zeiner's protocols involving 41 Tarahumara men took eight 14-hour days to eomplete; the data, as one might expeet of subjects who ean run for two straight days, was awesome. They ranged in age from 18 to 65, with an average age of 35. Women weren't tested because Zeiner was fearful of violating some possible taboo that might jeopardize the study. Communieation during the testing was handled by gestures or Zeiner speaking German to the Austrian nuns (who staffed the hospital), who translated the message into Tarahumara, and viee versa.

Their resting pulse rates averaged 50 and blood pressures averaged 110 over 70. Superior physical eonditioning, Zeiner believed, was probably the major faetor in preventing stress-related illnesses and eould play a role in lessening their physiologieal reaetions to aleohol. Contrary to eonventional wisdom, the data showed the Indians reaeted less physiologieally to a small dose of aleohol than Caueasians. In faet, Zeiner found that the Tarahumara absorbed aleohol faster than any group of subjeets reported in the seientifie literature. This was true though they had high levels of aeetaldehyde, a toxic by-product of aleohol metabolism thought at high levels to eause inereased heart rate, drop in blood pressure, and a flushed face. Maybe this apparent paradox could be explained by the Indians' eonditioning. To be surer, he would have to find several aeeulturated Tarahumara. The only one tested had physiologieal values similar to white Amerieans. On this tantalizing note, it was time to depart.

During the arduous trip out through the Sierra Madres, the VW bus seemed to be breaking down one part at a time. "Risk-takers" who drive need to be up on ear repair; Zeiner was able to fix or bandage everything until a roek slashed a hole in the oil filter and the warning light didn't switeh on. As they drove a short distanee in ignorant bliss, the oil leaked out and the



Arthur Zeiner, recruited by Jolly West to join the psychiatry department at the University of Oklahoma College of Medicine, studied alcohol metabolism and the related liver enzymes. *Photograph courtesy the University of Oklahoma Health Sciences Center Photographic Services.*

engine "eommeneed to fry," aeeording to Zeiner.

Within an hour, a logging truek happened along and towed them, via a 20-foot chain, to a town six hours away. From 8 p.m. until 2 a.m., Zeiner was in eonstant danger of impaling the bus on a six-foot steel boom protruding from the rear of the truek. Forward visibility was nil beeause the truek belehed dense blaek exhaust and kieked up clouds of dust. Sinee he eouldn't see the truek he was tethered to, Art rode the brakes to keep the chain taut on downhill stretches. As a result, the brakes also "got fried." Eventually, some Mennonites loaded Zeiner's bus onto their flatbed truck and hauled them to El Paso, where Zeiner rented a car and towed his wife's bus baek to her in Oklahoma City.

The Tarahumara trip turned out to be a metaphor for the rest of Art's seientifie eareer. For in the eight years left him, Zeiner eontinued to eonfront and overeome, or at least eireumvent, formidable obstaeles to the researeh he believed in and thought would make a lasting

scientific contribution—studying the effects of alcohol on different racial and ethnic groups.

Art hoped a key to understanding these differences could be in the levels of a liver enzyme, ALDH I, involved in breaking down acetaldehyde. According to Art's hypothesis, groups displaying aversive reactions to small doses of alcohol should have low levels of ALDH I. To find out, in 1980 he designed a study that included Oklahoma Indians because of an inference he had drawn from a study on Indian mortality. The rate of alcohol-associated deaths was many times higher among tribes in western Oklahoma than in the eastern part of the state. The western tribes should have less of the liver enzyme.

His grant proposals to NIH scored high, but never high enough to be funded. Zeiner and his OU colleagues, Jay Shurley, Oz Parsons, and Gordon Deckert, became convinced that Art's proposal was considered too controversial. By 1982, German and Japanese scientists were "doing three-fourths of the experiments I had planned," Zeiner said in exasperation. To improve his chances, he accepted the recommendation of a full-blood Indian and laboratory assistant, Deborah Jones-Saumty, to include psychological and socio-cultural data in his next proposal.

Again his proposal was "approved but not funded." He submitted the same $300,000 three-year proposal to the Indian Health Service. It was approved AND funded for July 1983, but bureaucratic snafus held up release of the money. Meanwhile, he conducted the tests on a few Cheyenne-Arapahos with mixed results. The sampling was too small. He needed the IHS money for the larger study. Funding for the first year was deposited in an Oklahoma City bank, but inexplicably wasn't released. Fed up, he and his wife, Harriet, a neuropsychologist, decided to take the six-month sabbatical to Copenhagen that they had had been planning. If the money was released, Oscar Parsons would oversee the project until his return. If it wasn't, the hell with it, he thought; he'd try another funding agency.

A month after the Zeiners left in September 1984, the first two years of funding were released. It was lousy timing, but at long last he could look forward to testing his hypothesis upon his return to Oklahoma. But in January 1985, Art suffered a severe seizure only days before he and Harriet were to return home. Tests revealed he had a malignant brain tumor, an astrocytoma. Surgery was performed in Copenhagen and again in Oklahoma City.

The operations and medications left him unable to work, but he struggled to gain control over his disease. In one unconventional method, he literally walked on a bed of hot coals. There were times when he seemed to be succeeding, but this battle was altogether different than overcoming obstacles in the Mexican mountains. In September 1985, he died at the age of 47.



Jolly West returned to OU many times over the years to deliver lectures and see old friends. He never failed to say how much he cherished his 15 years in Oklahoma City. He retired from his prestigious UCLA positions in 1989 and involved himself only with the few dozen projects and issues that interested him. In mid-1998, a back pain was the first sign of the cancer that would metastasize throughout his body. According to a friend, his last months were almost pure hell. He died at the age of 74 on January 2, 1999. Lengthy obituaries in *The New York Times* and the *Los Angeles Times* called him a charismatic leader in psychiatry and fittingly reported his long-standing and deep commitment to social justice.

Only the oldest of the three men still lives. Jay Shurley retired from OU in 1982, but went on to practice psychiatry and keep his hand into research for several more years. Today, his house in northwest Oklahoma City seems a bit cluttered with all the books, pictures (he was an accomplished photographer) and mementos of his scientific explorations and travels. Still standing tall and erect, he says he has a hard time believing that he is 82 years old. Even when he looks in the mirror he can't believe it. Even when he reflects on his past health problems: "Heart bypass surgery twenty years ago, and I'm shy of every organ that can be removed and not be dead. Still, I'm doing fine. I don't understand it, but I'll take it—considering the alternative."

He smiles and booms out his big laugh.

The White Coat: Symbol of Commitment

M. Dewayne Andrews, MD

Dr. Vannatta, faculty colleagues, families, and guests: I am happy and grateful to share this celebration and ceremony with you today. More important, I am excited about sharing it with you, the Class of 2004—my new fellow students of medicine. Yes, I said my fellow students. William Osler, one of the greatest physicians and teachers in the history of medicine, speaking of medical students and their teachers, said that we are all students of medicine, some just more advanced than others. As you begin your studies I hope you will find that this simple, earnest spirit runs through our college.

We are here today to focus on the values and traditions of this wonderful profession of medicine, this life of being a doctor. And we want to share this with your families and friends because they are such an important part of your lives. In a few minutes, some of the faculty will cloak each of you with a white coat. As you don this coat, you may ask, "Why is this so meaningful? Why this ceremony? What is so special about this white coat?"

It is special because it is a symbol of all that is noble and good about our profession. It is special because it is a symbol of our rich history. It is special because it is a symbol of the transformation that will occur in you over the next four years. It is special because it is a symbol that reminds us of our commitment as physicians to caring, honor, and service. Caring, honor, service – let those words echo in your mind.

Caring

American medicine and the American medical education system has made incredible advances over the past 30 years. We developed the world's most sophisticated medical science. We built the world's most advanced medical technology. And we deliver higher quality health care to more people than ever before. Yet, despite all these achievements, we suffer much criticism.

Do physicians seem less personal, less caring than in former times? To many in our society the answer is yes. The pace of modern life, the economic pressures on physicians, and the substitution of tests for talk all lead to such criticism. Physicians are urged to see more patients by giving each less time. But the care and management of a sick person entails much more than diagnosing illness and the mere understanding of disease and administering of treatment.

You must care for the entire patient—not just his disease. You must care for the patient as part of a family and a community. To do this, you must understand the emotions, the routine, and the daily drama that make up this single human life. Effective communication is at the heart of the interface between patient and physician. This takes time, and economic pressures conspire against it.

All individuals, regardless of education or background, come to a physician with varying degrees of uncertainty and fear. And illness always produces fear and anxiety. We know the fear of cancer is widespread, but just as common is the cancer of fear. You will learn to recognize it, often in its subtle forms. And the only cure is therapeutic conversation between the patient and a caring physician. This takes time, and we must find a way to preserve it.

The white coat must not be a barrier between our patients and us. It must represent a bond reinforced by our commitment to meaningful communication and caring. What the scalpel is to surgery, words are to the clinician. With caring words alone you can help so many. All physicians come to know this. The faculty will show you the way, but you must master the skill.

Today, your new coat is white as snow. Slowly, it will become stained with the fluids of

human illness and suffering. Like the coat, you will be stained with the sweat and tears of clinical experience, with the joy and tragedy of the human condition. And with each stain you will grow and be better prepared to meet the next challenge. If you will let them, those stains can be transformed into deeper understanding and more effective caring.

Over 70 years ago at the Harvard Medical School, Dr. Francis Peabody spoke to the medical students about the care of the patient. Today's physicians and teachers can still attest to the unerring accuracy of Dr. Peabody's insights in this famous passage of his essay.

"The good physician knows patients through and through, and his knowledge is bought dearly. Time, sympathy, and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

I also want you to remember that the white coat is only an article of clothing. It is not magic. The person under the coat is as complicated, vulnerable, and imperfect as the patients he or she touches. The coat will not protect you from life.

Recognizing that, you must learn to care for yourself and your family, and for your fellow students. I do not mean medical care here, but caring in a personal sense. There will be stress, pulling from many directions, and new demands on your time. Learn to balance these demands so that your own health and the well being of those you love remains intact.

Honor

Next is honor. Few people are as close to the nature of man as are physicians. Patients will share the most intimate aspects of their lives with you. They do so because they are in need, and they trust their doctor. Honor means that we never betray that trust and confidence.

In their daily actions with patients, families, physicians and other health care colleagues, the values and behaviors that physicians demonstrate are the foundation on which medical professionalism rests. Actions do speak louder than words.

Honor means that truthfulness, compassion, and integrity must be the strong threads from which the tapestry of our lives is woven. Ethical standards are the touchstone of our profession. We must never forget or forsake them.

In the past decade, the debate about health care has been dominated not by physicians, but by business, economic, and political voices. Medical professionalism is being seriously challenged by the industrialization of medicine. Honor means that we must stand firm against this erosion, that we must always serve the best interests of our patients—not those of insurance companies or corporate stockholders. We must never be afraid or reluctant to speak plainly on this point.

Honor means that we remain committed to our profession's most valued principles throughout our lives. The passing years will test each of us, but we must remain steadfast. When I think on this last point, I cannot help but recall these words from Alfred Tennyson's poem *Ulysses*:

"Though much is taken, much abides; and though
We are not now that strength which in old days
Moved earth and heaven, that which we are, we are –
One equal temper of heroic hearts,
Made weak by time and fate, but strong in will
To strive, to seek, to find, and not to yield."

Service

Third is service. Most important, of course, is service to our patients. I touched on that when I spoke about caring. It is fundamental to our existence. But now I want to speak of service to your profession and your community.

Medicine will reward you in many ways. But don't just take from it. Give back to it too. If you see things in our profession that trouble you, even as a student, don't turn your back on them. Work within the profession to change it and make it better. Don't be a cynic. Be a part of the solution. This requires time, energy, and service. Working with others in professional organizations and societies broadens your horizons and enlarges your perspective. We need your idealism, your energy, and your talents to make us better.

In 1961, in a time of transition, John F. Kennedy in his inaugural speech as President of the United States challenged all Americans in a memorable phrase. Perhaps I can bring home this point best by simply borrowing from President Kennedy and challenging you in the following way. Ask not what your profession can do for you; ask what you can do for your profession. Leave your mark – you'll find it provides its own special reward.

As for community, don't hide behind the white coat. Don't forget those who are less for-

tunate than we, those who are poor and under served. As time allows, get out in your community, join others who share your interests, roll up your sleeves and work for good causes. Physicians have always done this, but it is even more important now.

Commit yourself to something and champion it. Your life will be fuller. Don't underestimate the impact you and your concerned friends can have. Margaret Mead, the renowned anthropologist, said, "Never doubt that a small group of dedicated citizens can change the world, indeed it is the only thing that ever has."

This then, in my view, is the profession to which you have been called. Always there echoes and reechoes caring, honor, service.

Understand this profession and what it requires of you with gleaming clarity. Discipline yourself to accept and meet the demands that it will make upon you. And in the midst of this discipline remember that you must make time for yourself, love your family, and still laugh and play in order to preserve your own health.

Sure there will be difficult times, but you are embarking on such an exciting journey. Make the most of it. Go now and immerse yourself in learning the complex and fascinating science of medicine. Develop and hone your clinical skills and clinical art by eagerly meeting each new patient experience. Enrich yourself by learning how to truly communicate with people and care for them.

Soon you will be engaged in the service of the sick. Soon you will come to appreciate that with the knowledge and skills you are acquiring, with the warmth of your spirit and the strength of your character, with the laying on of your hands, and in response to your words, you can make the sick better and fill the dying with peace. These are humbling and great powers. Always deserve them.

Welcoming Remarks to the Class of 2004

Deborah McAlister, MS-IV

I am honored as a College of Medicine Student Body representative and I am rewarded as a person to have the opportunity to offer a warm welcome to each and every one of you—the class of 2004. Congratulations and welcome to the University of Oklahoma College of Medicine. I remember vividly sitting in similar seats at the first annual White Coat Ceremony three years ago—feeling like a fledgling in my newly earned white coat. The same coat I proudly wear today—albeit a little worse for wear after third year. I felt a renewed sense of excitement at being accepted to medical school—a sense of apprehension at the beginning of a challenging journey—a sense of inner pride in the profession I had chosen. As a matter of fact, I wasn't sure my heart was going to stay in my chest. But of course, as Anatomy and Physiology require, it did. And I didn't see my parents' hearts on the floor anywhere, so I guess they were able to maintain a reasonable level of pride too. Since each of you have just taken the oath of commitment, I'd like to say a few words about what commitment means to me as a medical student. Commitment is a strong word. It bears a great deal of responsibility in the medical profession. 1) Initially it is commitment to academics where during the didactic years you will build the foundation of knowledge that will allow you to become a good physician. 2) Then it requires commitment to people, to patients, to humanity—here you will build your compassion, your nurturing character, and skill in serving those who are suffering and in need. The challenge of responding gracefully with compassion to the patient with terminal ovarian cancer who has failed her third round of chemotherapy and knows there is no other treatment; the patient who has just been told they have an inoperable Klatskins tumor; the Korean child with leukemia who speaks no English when you walk in the room every morning and say, "Cuy bu nee do sa neka?" ("How are you feeling?) These patient situations are similar to the challenge issued to each of you in your reading *The Spirit Catches You and You Fall Down* and must be handled gracefully and compassionately. The third commitment is to your community where your knowledge, ability, and willingness to act will be respected. This may mean being the Class President, a mod representative, or sitting on the academic misconduct board. Later it may mean being the doctor on the sidelines, spending an afternoon at the County Health Department, or even testifying in a child abuse case. Commitment to your community, to your peers, to your class, to your college—It is important. Last but not least is commitment to your profession—a long-standing, honorable profession—to build, to teach, to continue the ART OF HEALING, to remember that wherever you are and whatever you do YOU represent the medical profession. In closing I would like to offer some friendly advice:

- Don't study on your bed – you will sleep. The highlighter stains on my comforter are proof!
- Be active in your class. Leadership is by example.

Some serious advice:

- Be persistent
- Stay committed and each of you will do well.

My hope for each of you—Laura, who climbed Mt. Rainier; Lacy, who vacationed in Paris; Natalie, Monique's little sister; Vail, who I met searching for his mod—is that when you reach fourth year you will remain as excited, enthusiastic, and as in love with this profession as I am. Once again, congratulations, welcome, and good luck. My thoughts are with each of you.

Oklahoma City Physicians Headed to Sydney

Brock Schnebel, MD, and David L. Holden, MD, have been selected to serve as Olympic physicians for the upcoming Olympic and Paralympic competitions in Sydney, Australia. Dr. Schnebel has been selected as the United States athletes' head physician; his duties will include scheduling 24-hour physician coverage with a team of ten other physicians, plus trainers, sports medicine specialists, and interns. Dr. Holden was selected as the 2000 swim team physician for the United States Paralympic Team; the Paralympics are held immediately following the Olympic Games and feature competition among more than 4,000 athletes with disabilities. Drs. Schnebel and Holden are orthopedic surgeons in Oklahoma City.



Brock Schnebel, MD, an Oklahoma City orthopedic surgeon, will serve as the U.S. Olympic Team's head physician in Sydney.



David Holden, MD, an Oklahoma City orthopedic surgeon, will serve as the U.S. Swim Team Physician for the 2000 Paralympic Games in Sydney, which will be held immediately following the Olympics.

Celebrating Women in Medicine Month

Once again, the AMA is recognizing September as Women in Medicine Month. This year's theme, "Making a Difference: Celebrating Physician Contributions," focuses on women physicians who are making special contributions to their communities or to the medical profession. The following suggestions from the AMA offer ideas for both individuals and organizations to recognize and celebrate Women in Medicine Month:

Networking Meal Function: share a meal together. Start an annual breakfast, lunch, or dinner hosted by your hospital, medical society, or medical organization. Use table tents, banners, and other items to reinforce the theme. Ask your leaders to recognize the contributions of women physicians and emphasize the need for their involvement.

Honor/Recognize Women Physicians: ask your organization to review the accomplishments of women physicians in your area. Is there one (or more) who deserve special recognition for their dedication to the medical profession? For example, you could recognize someone who is an outstanding role model for medical students and residents, or someone who is dedicated to serving people through outreach. Ask your society, hospital, or organization to consider creating an award to honor the professionalism and dedication of women physicians, honoring women physicians in an organizational publication, or giving out special items (prescription pads, pens, etc.) to celebrate Women in Medicine Month.

Special Programs: provide special educational or informational programs for women physicians during the month. The programs can focus on public health or women's health issues, or can honor a woman physician who works in the community or hospital.

Community Service: provide speakers to local schools on medical topics or careers in medicine for women. Develop an award for outstanding women physicians in local community service. Sponsor a "walk for women's health" event.

Correction: OSMA Annual Meeting Proceedings

In the minutes of the Opening and Closing Sessions of the OSMA House of Delegates (published in the July 2000 Journal*) the names of physicians running for and elected to the PLICO Board of Directors were incomplete. The following individuals ran for the PLICO Board of Directors: William Coleman, MD; Scott Dunitz, MD; Mayo Gilson, MD; David Harper, MD; Michael Haugh, MD; Carl T. Hook, MD; Ron Kreger, MD; Mukesh Parekh, MD; and David Selby, MD. The following individuals were elected to the PLICO Board of Directors: William Coleman, MD; Scott Dunitz, MD; David Harper, MD; Michael Haugh, MD; and David Selby, MD. The* Journal *regrets the error.*

Summer Fun at the Bricktown Ballpark!

This year's OSMA/AMA Medical Student Section picnic was held Monday, August 14 at the Bricktown Ballpark in downtown Oklahoma City. Attendees were treated to dinner and the Oklahoma Redhawks game courtesy the Medical Student Section (MSS). Amy Matzell, state MSS chair, and Jeff Sparling, Oklahoma City chapter MSS chair, emceed the event, and OSMA President Dr. Robert Weedn addressed the crowd. More than 260 people attended the picnic, including first-year medical students and their guests, physician members of the OCMS and OSMA, and staff and faculty of the OU Health Sciences Center. A great time was had by all!



American Society of Medical Association Counsel Addresses OIG Draft Compliance Guidance, Litigation Against MCOs

By Linda Scoggins, Esq., OSMA Legal Counsel, Hartzog Conger & Cason

I recently attended the mid-year meeting of the American Society of Medical Association Counsel (ASMAC). The meeting was held in Chicago in conjunction with the AMA Annual meeting, immediately following a two-day presentation on physician legal issues by the Health Law Section of the American Bar Association. As usual, the meeting was both informative and timely.

Topics of discussion included physician employment agreements, medical staff bylaws, OIG compliance program guidelines, managed care contracting, and class-action litigation against managed care companies. There was also a report from the Litigation Center of the AMA and the state medical societies on cases in which they are currently participating, as well as cases that have come to a conclusion in the last year. The two issues that took center stage at both the ASMAC meeting and the Health Law Section meeting of the ABA were class-action litigation against managed care companies and the recently released OIG Draft Compliance Program Guidance for Individual and Small Group Physician Practices ("Draft Compliance Guidance" or "Guidance").

With respect to the OIG's Draft Compliance Guidance, the outline prepared for the benefit of OSMA members in October 1999 continues to be operative. There were no big surprises in the Draft Compliance Guidance. Even though the Guidance is only in draft form, the fact that it is available for individual and small group physician practices makes it more important for physicians to have a compliance program in place. If you already have a compliance program in place, your compliance officer or manager should now look at the OIG's Guidance to ascertain if your current program addresses all the issues the OIG deems important. The 45-day public comment period on the draft ended July 27; OIG hopes to publish final guidance by this fall. The Draft Compliance Guidance may be found online at www.hhs.gov/progorg/oig/modcomp.

The OIG Guidance indicates that a compliance program is not mandatory for medical groups and physician practices; however, throughout the document, the OIG identifies many elements as "essential" for an effective compliance program. In other words, the OIG is saying that they are not requiring physicians to do any of this, but if they do not do what OIG says, they will be lacking "essential" elements of a compliance program, and OIG is likely to hold physicians responsible for not having a program that tracks their guidelines.

I have dedicated more than fifteen years to representing and advocating for physicians. My experience with physicians in this state is that the vast majority battle against all odds to take care of patients and keep some semblance of a profitable practice afloat. I know there will be consultants across the country licking their chops because of the Draft Compliance Program Guidance for Individual and Small Group Physician Practices. OSMA physicians must remember that the OSMA has an operative outline for its member physicians that can be used to create a compliance program tailored to your practice. The outline itself is **not** a compliance program. Because we have developed the outline, however, Hartzog Conger & Cason is able to create a compliance program for an individual or small group practice, or critique an existing compliance program, at a substantial savings.

The other issue discussed at length during the meetings was pending legislation against managed care companies. Approximately thirty class-action lawsuits have been filed against managed care organizations since the fall of 1999. Most, if not all, of those lawsuits are in very preliminary stages. Generally, class-action lawsuits are based on one, or a combination, of three legal theories: 1.) violations of ERISA; 2.) violations of the Racketeer Influenced and Corrupt Organizations Act (RICO); and 3.) violations of state prompt payment and deceptive trade practices law. These class action lawsuits have been filed by patients, providers, and government officials. Providers' RICO allegations in class-action lawsuits include that the managed care organization misrepresented commitment to quality care and used "coercive, unfair and fraudulent means to dominate physician-patient relationships," and that managed care organizations used faulty data to determine usual and customary rates for reimbursements. Providers' state law claims in class-action litigation includes alleged violation of consumer protection laws and violation of state laws regarding timely claims payment.

The US Supreme Court decision that came down after the ASMAC meeting was a resounding victory for managed care. In that case, the Court held that HMOs may not be sued under federal law for denials of coverage that are based partly on medical judgment (*Pegram v. Herdrich*, Case No. 98-1949, US 6/12/00). The *Pegram v. Herdrich* case was not a class-action case. It was a case brought by an HMO patient whose appendix burst while waiting eight days for an ultrasound. The physician made the patient wait so that the ultrasound appointment could be made with an HMO facility fifty miles away. The patient contracted peritonitis but recovered; the patient won a $35,000 malpractice award against the physician in state court. The patient also sued in federal court, claiming that her HMO breached its fiduciary duty to her under ERISA by giving financial incentives to a physician for cutting

medical costs. The Supreme Court opinion warns that imposing federal liability for efforts to reduce costs—the entire purpose of managed care—could destroy HMOs altogether. In "an HMO system, a physician's financial interest lies in providing less care, not more," Justice Souter acknowledged. "The check on this influence…is the professional obligation to provide covered services with a reasonable degree of skill and judgment in the patient's interest." In other words, based on current law, the burden and potential liability rests totally with the physician. Consequently, the Court signaled that the proper venue to resolve these cases is the legislative venue, not the judicial venue.

I believe the *Pegram* decision seriously undermines the pending patient class-action lawsuits against health plans. Many of those lawsuits rely on ERISA claims along with claims under RICO. However, *Pegram* should have little, if any, effect on the class actions brought by providers for health plan violations of state law. Thus far, however, no physician has been certified as a representative of a class, and no class-action lawsuit has gotten beyond the motion to dismiss stage. In other words, it is far from certain that such suits will ultimately succeed. Reality suggests that the legislative and regulatory arenas are more likely sources for meaningful changes in the way the managed care industry is organized and overseen.

If you have any questions about issues discussed at the ASMAC meeting, and/or need assistance with a compliance plan for your office, please do not hesitate to call Linda Scoggins, Esq., OSMA Legal Counsel, at Hartzog Conger & Cason, 800/632-8058.

LETTERS TO THE EDITOR

TO THE EDITOR:

I like the new look of our Oklahoma State Medical Association *Journal*. The highlights listed on the left side of the front of the *Journal* are useful, and the pictures on the front of the *Journal*. I hope this will continue.

I think it would be nice if you would invite the doctors of Oklahoma to submit photographs of medical interests that might make good subjects for the cover of our *Journal*. It can have a very positive impact for the Oklahoma State Medical Association public relations.

I have long opposed the use of photographs of various art objects on our *Journal of the American Medical Association*. I have written the Editor and the President of the American Medical Association and expressed my dissatisfaction with this policy. I feel it would be much more appropriate to have paintings, photographs, and other depictions of various medical subjects, both past and current, which would have a positive influence for medicine in general, or perhaps draw attention to some of the contents of the *Journal*.

I strongly resent the *Journal's* paternalistic impression that they are somehow contributing to the cultural education of physicians. We each have our own ideas of what a cultural education should represent and I do not believe the American Medical Association should try to determine that for me or other members.

When I made objection to the placement of art on the front of our *Journal*, the editor stated that there was no possibility of change because more letters were received about the cover than any other aspect of the *Journal*. I did not want to point out that perhaps the reason for that was that many people simply looked at the cover and then threw the *Journal* in the waste basket.

I did point out that I felt that the front of the *Journal* should contain something of medical interest and that there was a good opportunity to further medical education according to what was depicted on the cover. I hope our *Journal* will continue to use the cover to further the medical interest and education of the members of the Oklahoma State Medical Association.

Joseph W. Hayhurst, MD
Oklahoma City

TO THE EDITOR:

If you never wrote another editorial you would still have my lasting admiration for that of July 2000. It was brilliant as well as courageous. You said much of what has been on my mind for many years.

There are many issues that deter young doctors from joining the unified system. This in itself is an insult to the intelligence of any doctor—we are one of the states that do this.

Also, I like your reference to the "entrenched." This is so true—and again, insulting to the membership. Things will change with leaders of your caliber. Keep it up!

W.T. Holland, MD
Tulsa

In Memoriam

1999

Nolen L. Armstrong, MD September 12
George R. Randels, MD October 2
George B. Carter, MD October 7
John Robert DeBiase, MD..... October 17
Theodore Turnbull, MD October 19
Sol Wilner, MD..... October 31
Malcolm Horne, MD November 3
William Clark Cheek, MD..... November 11
Bill B. Elrod, MD November 17
Donald E. Johnson, MD November 18
Allen E. Greer, MD November 19
Beverly Colvin Chatham, MD December 2
Norman A. Cotner, MD December 3
Alan Knight Braly, MD December 9
Wilson David Steen, PhD December 12
James Thermon McInnis, MD December 18
Douglas Lyons Polk, MD..... December 19
Thomas S. Llewellyn, III, MD..... December 26
John Preston McDaniel, MD December 27
Joe Earle Tyler, MD December 31

2000

Hwan X. Youn, MD January 2
Donald Charles Barney, MD January 4
Charles E. Cook, MD January 13
Lynn H. Harrison, MD January 16
Kenneth C. Hoffman, MD January 17
Richard E. McDowell, MD.....January 17
Wilson E. Roark, MD January 28
Orval L. Parsons, MD..... January 29
James William White, MD February 1
Harry L. Deupree, MD February 3
James L. Nicholson, MD February 3
Leo Meece, MD..... February 5
Homer A. Ruprecht, MD February 6
William G. McCreight, Sr., MD March 10
Armond H. Start, MD..... March 30
Billy E. Blevins, MD April 3
Willis E. Lemon, MD April 21
Roy A. Lawson, MD April 22
Benjamin F. Gorrell, MD..... April 29
Adolph N. Vammen, MD May 8
Ross P. Demas, MD May 15
William C. Stone, MD May 18
Hubert M. Anderson, MD..... May 22
Jack G. Glasgow, MD June 7

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Deaconess Hospital: Yvonne Curtright 405/604-4979

Sept. 7,14,21,28	Cancer Conference	12:15 pm	1 hour
Sept. 18	"The Role of Insulin in Type 2 Diabetes"	6:30 pm	1.5 hrs

Duncan Regional Hospital: Amy Wade 580/251-8648

Sept. 14	Vascular Biology	Noon	1 hour
Sept. 26	Geriatrics & Depression	Noon	1 hour

Integris Baptist Medical Center: Donna Schoenfelder 405/949-3284

Sept. 1,15	Tumor Board	7:00 am	1 hour
Sept. 8	Cancer Conference	7:00 am	1 hour
Sept. 11	"Rapid Breakthrough Performance Improvement"	7:00 am	1 hour
Sept. 15	OB-GYN: "Uterine Fibroid Embolization"	7:00 am	1 hour
Sept. 15	Managed Care College	10:00 am - 6:15 pm	
Sept. 16	Managed Care College *(cont'd)*	8:00 am - 5:00 pm	
Sept. 17	Managed Care College *(cont'd)*	1:00 pm - 5:00 pm	
Sept. 19	Ophthalmology CME	Noon	1 hour
Sept. 19	"Spirituality, Prayer & Modern Medicine"	9:00 am	3 hrs

Integris Bass Baptist Health Center: Carrie Patterson 580/548-1256

Sept. 28	"The First Three Hours of Coronary Care"	12:15 pm	1 hour

Mercy Health Center: Debbie Stanilla 405/752-3806

Sept. 7	"Artificial Nutrition & Hydration"	12:15 pm	1 hour
Sept. 14	"Pathophysiology of Fear & Medical Fear Disorders"	12:15 pm	1 hour
Sept. 21	Antibiotic Uses & Abuses	12:15 pm	1 hour
Sept. 28	"Neck Masses"	12:15 pm	1 hour

Norman Regional Hosptial: Joyce Nolen 405/307-1398

Sept. 27	"Sports Injuries For Primary Care"	12:15 pm	1 hour

Integris Southwest Medical Center: Jonathan Stotler 405/636-7087

Sept. 6	"Depression"	12:15 pm	1 hour
Sept. 13	"Hormone Replacement Therapy"	12:15 pm	1 hour
Sept. 20	"Geriatrics & Gerd"	12:15 pm	1 hour
Sept. 27	"Pain and New Guidelines for JCAHO"	12:15 pm	1 hour

St. Anthony Hospital: Sandy Coury 405/272-6358

Sept. 7	Cancer Conf.: TBA	7:00 am	1 hour
Sept. 11	Med. Grand Rounds: "Rheumatoid Arthritis"	8:00 am	1 hour
Sept. 18	Heart Conf.: "Expediting Care with GPIIb/IIIa In Patients with Unstable Angina: Optimizing Pre-Treatment Pathways"	8:00 am	1 hour
Sept. 21	Cancer Conf.: TBA	7:00 am	1 hour
Sept. 21	Behavioral Medicine Share: "Anxiety Disorders"	11:45 am	1 hour
Sept. 25	Med. Grand Rounds: TBA	8:00 am	1 hour

St. John Medical Center: Gail Hilst 918/744-2875

Sept. 5	Critical Care Conf.: "Acute Renal Failure"	Noon	1 hour
Sept. 7	Critical Care Conf.: "Valvular Heart Disease & Echocardiography"	Noon	1 hour
Sept. 12	Critical Care Conf.: "Pulmonary Thromboembolism"	Noon	1 hour
Sept. 14	Critical Care Conf.: "Abdominal Problems in the ICU"	Noon	1 hour
Sept. 19	Critical Care Conf.: "Shock"	Noon	1 hour
Sept. 21	Critical Care Conf.: "Guillian Barre Syndrome"	Noon	1 hour
Sept. 26	Critical Care Conf.: "Subarachnoid Hemorrhage"	Noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator at 405/843-9571 or 800/522-9452.

Strength in Unity

Do you belong to a county that doesn't have an organized Alliance? If your answer is yes, you can become a member of the OSMA Alliance as a member-at-large—or even start a county Alliance of your own. As a federated state, we believe that our strength is in our unity; that strength in unity is also what we are striving for in the OSMA Alliance.

As a county Alliance member you are automatically a member of both the OSMA and AMA Alliances. Membership in the Alliance provides many opportunities for personal growth through leadership training programs and community involvement through the various resource programs available. Everyone in the Alliance feels that we are fulfilling a special need in Oklahoma. As an organization we have information to help counties focus on leadership, health promotion, and fundraising.

Along the way we have made good friends, found a medical support group, and managed to have some fun!

If you are not a member of the OSMA Alliance, I encourage you to join this unique organization consisting entirely of physicians' spouses. If you and at least four or five others are interested in creating an Alliance in your county, please contact me at 405/447-4940. As Vice-President of New Alliance Development, I would be happy to help you organize a group like our other Alliances across Oklahoma.



Sandra Hook, Vice-President of New Alliance Development

Remember, what we can't do alone, we can do together—"Strength in Unity."

"Membership in the Alliance provides many opportunities for personal growth through leadership training programs and community involvement through the various resource programs available."



THE LAST WORD

GHB and GBL Now Classified Substances

The U.S. Drug Enforcement Agency (DEA) announced this spring that gamma hydroxybutyric acid (GHB) and its precursor, gamma butyrolactone (GBL), now have classifications as the result of a bill signed by President Clinton. GBL is now a List I chemical and GHB is a Schedule I controlled substance. DEA states that there is currently no licit use for GHB, which is a central nervous system depressant that is not approved for use in the United States. GHB is being abused by high school and college students at "rave parties," by body builders for its alleged anabolic effects, and in cases of sexual assault. Effects of the drug include drowsiness, dizziness, nausea, visual disturbances, unconsciousness, seizures, severe respiratory depression, and coma. More than 5,700 overdoses and law enforcement encounters with GHB in 45 states have been documented by DEA; the agency has documented 65 GHB-related deaths. According to DEA, GBL is being abused due to its rapid conversion to GHB after ingestion.

AMA Foundation Selects New Officers for 2000-2001

The American Medical Association Foundation has announced the election of new officers for the 2000-2001 year: Herman I. Abromowitz, MD, of Ohio, president; Bruce A. Scott, MD, of Kentucky, vice-president; Arnold P. Gold, MD, of New York, secretary; and Leo M. Henikoff, MD, of Illinois, treasurer. This year marks the 50th anniversary of the AMA Foundation, the philanthropic arm of the American Medical Association.

September Health Observances

September is...

Baby Safety Month
Children's Eye Health/Safety Month
Gynecologic Cancer Awareness Month
Healthy Aging Month
Leukemia Awareness Month
National Cholesterol Education Month
National Pediculosis Prevention Month
National Sickle Cell Awareness Month

The following observances are also scheduled in the month of September:

September 1-7
Labor Day Checklist of Health/Safety
National Child Injury Prevention Week

September 4-5
Annual Jerry Lewis MDA Labor Day Telethon

September 10-16
5-a-Day for Better Health Week
Hearing Aid Awareness Week

September 17-23
National Rehabilitation Week
National Reye's Syndrome Week

September 19-25
Prostate Cancer Awareness Week

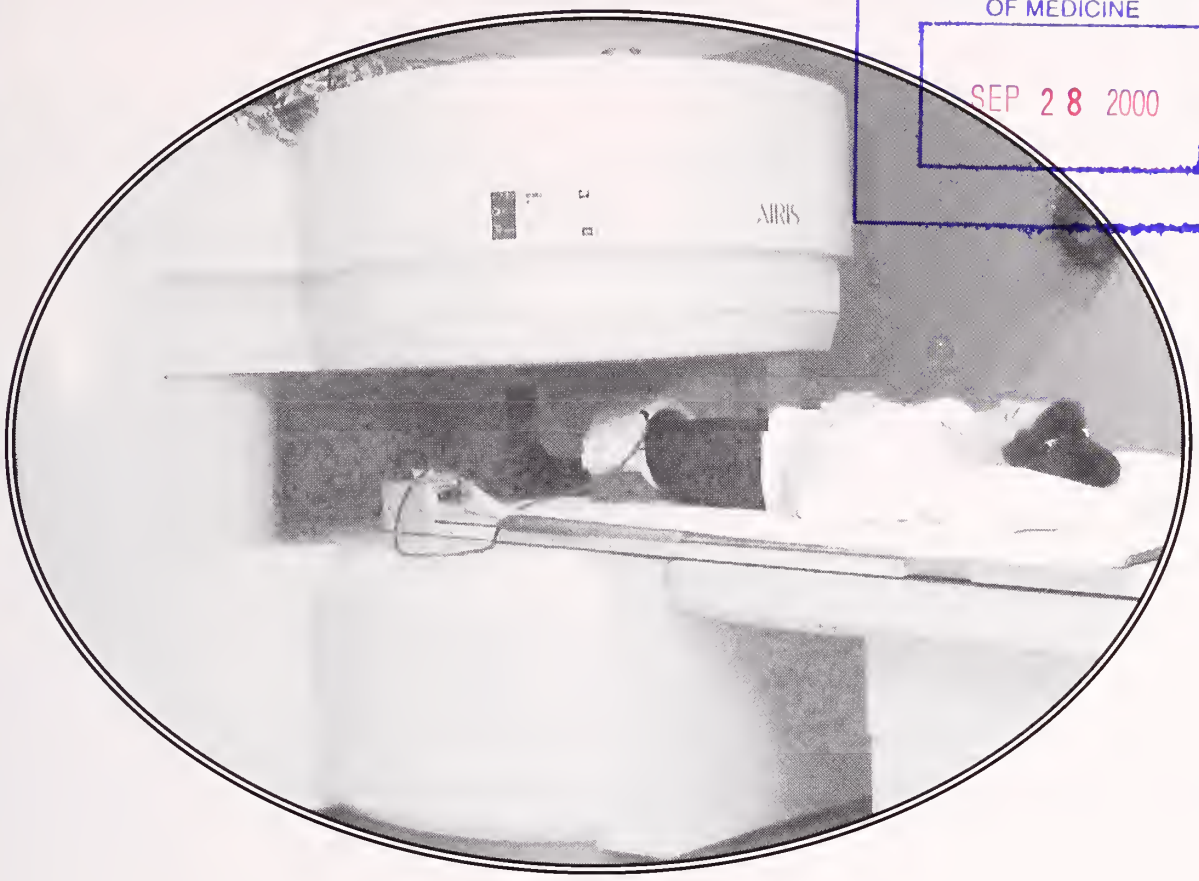
September 23-24
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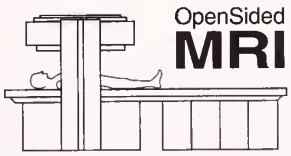
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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

INSIDE:

A History of the OU College of Medicine 475

Medical College Deans 483

History of Electrocardiology and Electrophysiology 486

Caring for Oklahoma's Children 489

Full-Time Clinical Department Chairs 493

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JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

OCTOBER 2000 VOL. 93, NO. 10

EDITORIAL
A Century of Nourishment 471
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE
SQ 692: Protecting the Health of Oklahomans 473
ROBERT J. WEEDN, MD, DUNCAN

SPECIAL
A History of the University of Oklahoma College of Medicine: Perspectives on Funding the Educational Mission 475
JERRY B. VANNATTA, MD, OKLAHOMA CITY

SPECIAL
Medical College Deans at Critical Stages 483
EDWARD N. BRANDT, JR., MD, PHD, OKLAHOMA CITY

SPECIAL
The History of Electrocardiology and Electrophysiology at the University of Oklahoma 486
RALPH LAZZARA, MD, OKLAHOMA CITY

SPECIAL
Caring for Oklahoma's Children: The Department of Pediatrics and Children's Hospital of Oklahoma 489
SANA SROUJI RETTIG, OKLAHOMA CITY; TERRENCE L. STULL, MD, OKLAHOMA CITY

SPECIAL
Full-Time Clinical Department Chairs: Time of Transition 493
M. DEWAYNE ANDREWS, MD, OKLAHOMA CITY

SPECIAL
An Analysis of Factors Associated with Seat Belt Use: Prevention Opportunities for the Medical Community 496
DARYL R. BAKER, MPH, OKLAHOMA CITY; ROSS CLARKE, PHD, OKLAHOMA CITY; EDWARD N. BRANDT, JR., MD, PHD, OKLAHOMA CITY

NEWS
In Memoriam: Brenda F. Hays, 503...Brumback Establishes Endowed Professor, 503...Influenza Vaccine Supply Delays, Shortages Expected, 504...CDC Influenza Vaccine Recommendations, 504

DEPARTMENTS
From the OSDH, 505...In Memoriam, 507...Obituaries, 507...CME, 510...Alliance, 511...The Last Word, 512



ABOUT THE COVER
The University of Oklahoma College of Medicine celebrates its 100th year. Art Direction by Transcript Press, Norman.

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A Century of Nourishment

You might want to take a moment to look closely at this edition of the *Journal*. It celebrates the 100th anniversary of the University of Oklahoma College of Medicine by publishing a collection of articles that discuss the political and historical perspective of this educational institution's journey. One hundred years of training Oklahoma's sons and daughters in the art and science of medicine.

Roughly thirty percent of the membership of the OSMA received their medical training at the University of Oklahoma Health Sciences Center, making the College of Medicine the single largest producer of physicians for this state.



A common thread woven throughout the history of this medical school is the conflict between vision and resource. The stories of political intrigue and successes in funding that have delivered the OUHSC to an honored place in history make a good read. As one who lived through some of those years, it is good to finally see the process from someone else's perspective.

And then there are the giants that walked among us, the visionaries that took the risk of sweat equity in an endeavor in which there was minimal reward and less compensation—titans who took a struggling institution and molded it into a viable place of learning. The historical perspective can sometimes make these physicians seem larger than life. In reality, they are folks like you and I that have put their skills to the task of developing a dream.

Over this century there have been continued financial concerns. Training medical students is not an inexpensive endeavor. Funding oftentimes is the rate-limiting step. Funding is also often the political weapon, making medical education a pawn in the often-bizarre game of Oklahoma politics.

But through it all the vision of a few became reality.

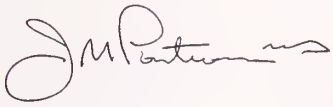
Then there are the histories that celebrate the unique contributions that have come from sections within the College. Pediatrics, medicine, and cardiology departments have articulated their histories and their vision for the readers of the *Journal*. Many of us have benefited from the educational mission of these departments and their faculty. Many of us carry the stories of intimidation and intensity, of sweat and relaxation, and of "unusual" personalities and delivery styles.

As a graduate of the University of Oklahoma College of Medicine, I found myself reading the articles with a bit of anticipation. It was as if someone had finally put the pieces of a puzzle together for me. The histories outline the contributions of some wonderful leadership. I always believed that I came away from the College of Medicine with a wonderful clinical education. It was not until my residency that I was able to see how it stacked up against other physicians trained in other medical schools. As a medical school, the University of Oklahoma College of Medicine is known for producing physicians skilled in the clinical arena.

"Alma mater" is the term used by folks to explain a relationship to the College of Medicine. I believe that alma mater is translated "nourishing mother" from the Latin. It evokes an image of an educational system that sustained us as we came into the world of medicine as unsuspecting, novice students—a gentle correction here, a bit of encouragement there—providing all the necessary pieces of an education that prepared us for the future. The process is rich with history and conflict and intrigue, yet it is a process that works.

How often do we return to the place that sustained us, the place that molded our behavior and say thanks for the effort that you put forth on our behalf?

Will you join me as we celebrate the last one hundred years...and look forward to the next hundred in anticipation of great things....



J. Michael Pontious, MD
Editor-in-Chief

"How often do we return to the place that sustained us, the place that molded our behavior and say thanks for the effort that you put forth on our behalf?"

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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SQ 692: Protecting the Health of Oklahomans

The number one legislative priority of your state medical Association and its Physicians' Campaign for a Healthier Oklahoma this year has been to protect and preserve Oklahoma's estimated $2 billion share of the tobacco settlement over the next 25 years. If a safe repository for these funds is not created, the money will flow into the state's general revenue fund and can be used by the legislature for any purpose they see fit. In previous legislative sessions, attempts were made to create a statutory trust fund for the tobacco settlement monies; those attempts were unsuccessful. However, a statutory trust fund could be tapped by the legislature for any needs they felt were paramount at the time.

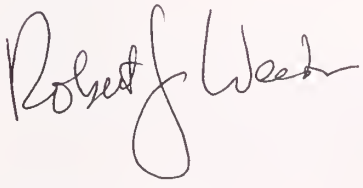


Hence the concept of creating a constitutional trust fund as proposed in State Question 692. A constitutional trust fund is created by a vote of the people and can only be changed by another vote of the people—not the legislature.

The OSMA has joined the Oklahoma Coalition on Health and Tobacco, a task force formed to promote passage of SQ 692 that will be voted on during the November 7th general election. SQ 692 proposes a constitutional trust fund and associated governing structure to protect a large percentage of Oklahoma's tobacco settlement monies. If passed, the trust fund will receive 50% of the revenue from tobacco settlement payments in the first year (2002) and an additional 5% each year for the next five years, capping out at 75% of each payment from then on. Only the interest can be spent on an annual basis and only for the following purposes: tobacco prevention and cessation programs; health care programs with an emphasis on children; research on cancer and other tobacco-related diseases; programs designed to enhance the well being of senior citizens; and education programs. Oklahoma voters must pass SQ 692 on November 7 for the trust fund to be established. Apathy or the automatic NO vote could easily defeat this question.

Support for SQ 692 is bipartisan; members of the task force include Attorney General Drew Edmonson, State Treasurer Robert Butkin, Governor and Mrs. Keating, House Speaker Loyd Benson, Senate President Pro Tempore Stratton Taylor, Lieutenant Governor Mary Fallin, and many other public officials, as well as myself as OSMA President. Your OSMA has contributed $15,000 to the campaign on behalf of its membership and a number of you, as individuals, have also contributed to the fund-raising effort to support passage of SQ 692.

It is imperative, however, that we carry the message and the information referable to this critically important issue to the public and our patients. A two-page fact sheet on SQ 692 is included in this issue of the *Journal* for your information and can be copied and distributed to patients and the general public (see pages 501-502). Please make a personal effort and encourage your colleagues, office staff, friends, and neighbors to inform all voters about SQ 692. After all, tobacco use is the number one preventable cause of death and disability in Oklahoma, and is estimated to cost the people of Oklahoma nearly a billion dollars a year in medical expenses and lost productivity. Your effort will make a difference in the health of Oklahomans.



Robert J. Weedn, MD
OSMA President

"Oklahoma voters must pass SQ 692 on November 7 for the trust fund to be established. Apathy or the automatic NO vote could easily defeat this question."

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Bylines may contain no more than **six** names and shall include only those individuals who can attest that they have contributed to the conception and design or analysis and interpretation of data, drafting the article or revising it critically for important intellectual content, and the final approval of the version to be published. Other contributors may be recognized in an acknowledgment.

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A History of the University of Oklahoma College of Medicine: Perspectives on Funding the Educational Mission

Jerry B. Vannatta, MD

This paper discusses the history of the University of Oklahoma College of Medicine. The history from the perspective of the political environment has been published by Mark R. Everett[1,2] and Alice A. Everett,[2] and the third edition of that series will be published soon by Regents Professor Mark Allen Everett, MD. These volumes are essential reading for a thorough understanding of the history of the college. In this paper, I will concentrate on the history of funding the educational mission. It is an interesting study of the politics of a state institution and reflects the history of the chronic underfunding of higher education in the state of Oklahoma.

Beginnings: The First Ten Years (1900-1910)

The University of Oklahoma was founded by the First Territorial Legislative Assembly in June 1890. David Ross Boyd became its first president. In 1900, the records show that the School of Medicine grew out of the School of Pharmacy, which had been established in 1893. President Boyd secured the services of Dr. L.N. Upjohn to head the medical department, and he is considered its first dean. Dr. Upjohn graduated from the University of Michigan in 1900. His brothers established the Upjohn Company in Kalamazoo, Michigan. Dr. Upjohn served as dean of the College of Medicine from 1900 to 1904. The medical school at that time was a two-year course intended to prepare students to go on to a medical school of advanced standing. In 1901, the University regents authorized a sum of $525 for class instruction and equipment and approximately $3,000 per year for three salaried professors.

In 1906, under the deanship of Dr. Ray Stoops, the medical school was accepted into the Association of American Medical Colleges (AAMC). The entire instruction in the two-year curriculum occurred on the Norman campus and included no clinical instruction.

The Council on Medical Education of the American Medical Association performed site visits at all medical schools in 1907. Medical schools were classified as: A (approved and acceptable), B (on probation), or C (unacceptable). In 1907, the OU College of Medicine was given the rating of A.[1]

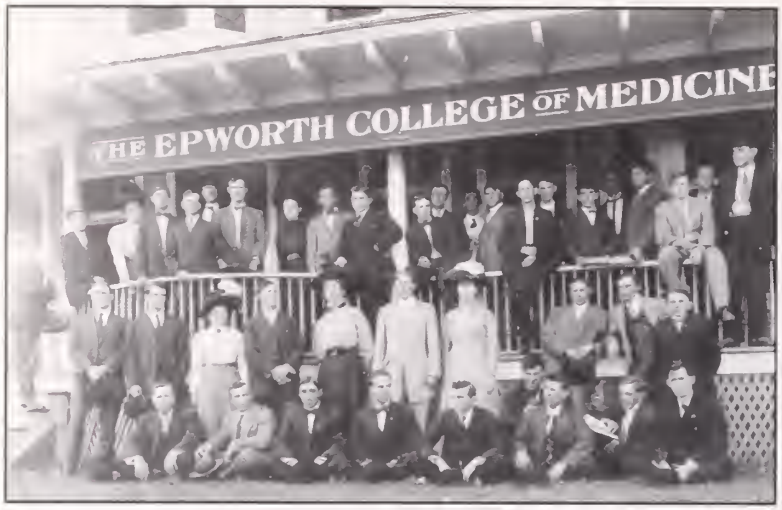
Specific dollar amounts allocated to the medical school apart from the University are difficult to find in these early years. However, evidence is beginning to surface by 1907-1908 that Oklahoma needs to expand to a four-year curriculum. Apparently, it was also becoming evident that appointments at the University in general, and the medical school specifically, were very political.

By 1909, there were nine faculty members with average salaries of $2,000, a total of approximately $18,000 for that year. Specific data for operating funds is not available.

In 1910, two significant events occurred: the OU medical school developed a four-year curriculum, and the Flexner Report[3] was published. Flexner published his assessment of medical education in every state of the union. Of Oklahoma he says:

"The new commonwealth of Oklahoma may, if wise, avoid most of the evils which this report has described; for though they have already appeared, they have not taken deep root. Immigration—of physicians, among others—has been so rapid that

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The Epworth College of Medicine closed its doors in 1910 after approaching the University of Oklahoma Board of Regents with a proposed merger. Twenty faculty members from Epworth joined the OU College of Medicine.

the state has easily three times as many doctors as it needs. They pour in from the schools of St. Louis, Kansas City, and Chicago. If, however, the state wishes a high-grade supply only, it must speedily define a standard such as will (1) suppress commercial schools—as, for example, that now nominally belonging to Epworth University—and (2) by the same action exclude inferior doctors trained elsewhere. Having done this, only an institution with considerable resources, derived either from taxes or from endowment, will even attempt to conduct a medical school in the state: which is as it should be.

The state university is of course marked out for the work. Its present modest beginning must be developed. Perhaps it will have at once to occupy Oklahoma City with a clinical department so as to obtain control of the field; though, if its sole right could be established with that, the project might well be delayed for a time. A good medical school is so costly that a new university does not want to anticipate the responsibility. Possible expenditures on such a department have in a way been crippled in advance by the absurd duplication of state institutions. There are 26 state-supported educational institutions in Oklahoma. In other respects, the people of the state have been quick to profit by the experience of other sections. Oklahoma City has not in its building recapitulated the phases of growth elsewhere. Its streets are of asphalt, its large buildings are fire-proof, their plumbing modern; they have begun with enamel, not with tin or zinc, bathtubs. Why do they not in the same way avoid the weary and costly errors in educational organization that the states about them have one after the other made? Ordinary intelligence, surveying the states of the middle west today after their educational experience of the last thirty years, could reduce its lessons to a few simple propositions which would be universally accepted. No two judges would differ as to the principle that state institutions of higher learning should be concentrated in a town of assured future; that proprietary medical schools should be forbidden, etc. The older states are painfully correcting or paying for their blunders: should Oklahoma, to soothe the local pride of this little town or that, run up a bill of the same sort?"[3]

At the time of this report, there were two medical schools in Oklahoma: OU Medical School in Norman, and Epworth Medical School (Epworth University was the forerunner of Oklahoma City University). The Flexner report suggested that the OU medical school should conduct its clinical work in Oklahoma City. The Board of Directors of Epworth College of Medicine approached the University of Oklahoma Board of Regents concerning a merger. Epworth closed in 1910, and the faculties of the two medical schools were merged; twenty faculty members from Epworth came to teach at the OU College of Medicine. At the close of this decade, three years following statehood, there was but one medical school in Oklahoma.

Following the Flexner Report (1910-1916)

Of the thirty clinical faculty members in place following the merger of Epworth and the University of Oklahoma medical school, twelve remained in teaching positions for 25 years.[1] This added to the stability of the college during some of the most politically turbulent times at the University.

The basic sciences remained on the Norman campus; the clinical years were completed in Oklahoma City at the headquarters at NW 10th and Lee. In 1911, the Board of Regents shifted $75,000 originally assigned to the law school to erect buildings on an Oklahoma City site for the medical school.

In 1911, Dr. Robert Williams was elected dean. In a report to the Board of Regents he presented annual funding statistics for medical schools surrounding our state: University of Kansas Medical School, $170,000; University of Texas Medical School, $95,000; and Tulane Medical School, $101,000. That year, the University of Oklahoma College of Medicine was allocated $19,000 of total funding.[1]

Clinical education was felt to be too diffuse as it was spread among some twelve small hospitals in Oklahoma City. The State Medical Association and the medical school combined efforts to begin a campaign to build a teaching hospital designed for indigent care. Meanwhile the College of Medicine leased space in the Rolater Hospital, owned by Dr. J.B. Rolater. By 1912, the College of Medicine, primarily because of low financial support and poor clinical facilities, was reduced in rating by the AAMC to Class B. To address these problems, the Governor attracted Dr. LeRoy Long of Caddo, a general surgeon, to accept the office of Dean of the College of Medicine.

Dr. LeRoy Long Builds The College

Dr. Long was dean from 1916 to 1931. This was a very crucial time for the college. Early in Dr. Long's deanship, Robert Lee Williams was Governor of Oklahoma—a circumstance that was fortunate for the medical school. Governor Williams seemed to understand the need for an infusion of funds to build the medical school.

During Dr. Long's fifteen years in the Dean's Office, he raised admission standards, secured legislation for a new University Hospital (1917), saw the Hospital constructed (1919), and returned the College of Medicine to Class A status (1920) with the AAMC.

University Hospital Constructed (1919)

Governor Williams decided that a new University Hospital to support the medical school was more important than a dome on the state capitol, and he transferred the necessary funds for the new hospital's construction. Not all were supportive of this very important effort. Dr. Rolater, with his obvious financial stake at risk, led a group of private physicians to oppose the effort. Following delays and rising costs, the hospital was built. The new hospital was dedicated November 13, 1919. It was reported to cost approximately $300,000.

Following construction of the new hospital building, and restoration of Class A status, considerable momentum was gained. The State Medical Association called upon the legislature to allocate enough money to build a new medical school building next to the hospital in Oklahoma City. However, this would not occur until 1928.

The dean of the College of Medicine was placed in charge of University Hospital. From the outset there was disagreement on who should receive care at University Hospital, with candidates varying from recent veterans of World War I to indigent patients to crippled children. Financing the care of indigents became a critical issue from the beginning and has continued to the present time. The state appropriation to University Hospital for operations in 1920 was $175,000, estimated to be approximately $100,000 less than required.[1]



Funding for University Hospital, constructed in 1919, was secured by Dr. LeRoy Long during the governorship of Robert Lee Williams.

In 1923, the legislature appropriated $100,000 for a medical building on the Norman campus (House Bill 15). The legislature had ignored Dr. Long's request for a building on the Oklahoma City campus. In 1925, the tenth legislature, with House Bill 277, appropriated $186,000 for a new medical school building in Oklahoma City.[1]

Funds for University Hospital were appropriated directly by the legislature, while funds to support the medical school were appropriated through higher education and the Board of Regents. This led over the years to decreased funding of higher education in Oklahoma, even though indigent care has always been funded at levels below costs.[4]

The legislature, through Senate Bill 27 in 1927, authorized the building of Crippled Children's Hospital at a cost not to exceed $300,000. The legislature also attempted to create a means of paying for the care of these children, but the special tax was found unconstitutional by the Oklahoma State Supreme Court.[5]

This was a great decade for growth for the medical school. Dr. Long saw in a few short years the construction of the new Children's Hospital and the medical school building, and



In 1925, the Oklahoma State Legislature appropriated $186,000 to build the medical school in Oklahoma City; the building was constructed in 1928.

the establishment of student loans through the philanthropic efforts of Lew Wentz, an oilman from Ponca City. In 1930, the outpatient clinics were moved into the hospital buildings, where they still remain.

An honors program was established in the late 1920s through which a medical student who performed original research could graduate with honors. The first PhD in this program was granted in 1929.

Oklahoma, in 1930, saw not only financial catastrophe from drought and depression, but also experienced the election of the most vitriolic enemy of higher education in our history, Governor William Murray. Murray harassed college presidents and faculty. He coerced campaign contributions from faculty and decreased higher education funding.[1] This spew of venom spread to Dean Long in the medical school, and in response to undue attacks, Dr. Long resigned in 1931.[1] That political fatality ended a most remarkable era of growth and maturity at the University of Oklahoma College of Medicine, and the career of quite possibly our most demonstrably successful dean.

Lewis J. Moorman, MD, was named to succeed Dr. Long as dean. We now name our most academically talented graduate (first in the class) the Moorman Scholar, and provide him or her with a copy of his autobiography, *Pioneer Doctor*.[5]

Postgraduate medical education had been present in the medical school since 1912, but in the 1930s it floundered. Funding was not available, so most of the cost was borne by the trainees themselves. In 1934, under Governor Murray, funding for postgraduate education was withdrawn, which would soon lead to the medical school being once again on probation. The Oklahoma State Medical Association continued the program with private physicians contributing most of the costs.

In addition to the problems in postgraduate education, disagreements arose between the dean of the college and the business managers of the hospitals, which were more clearly controlled by the legislature.

Following the chaotic years of the Murray administration, with its vast interference in higher education, the medical school found itself on probation in 1936. The report by the AAMC cited political interference as the primary reason for the probation.[2]

In 1944, George Lynn Cross became president of the University of Oklahoma. His presidency began with controversy over accounting policies at the medical school and University Hospital. Dr. Cross brought a sense of confidence and calm to the faculty of both the Norman and Oklahoma City campuses. However, this calm was short-lived as budget shortfalls were on the horizon. There were budget deficits for the school of medicine as well as the hospitals in both the 1945-1946 and 1946-1947 budget years.

In 1946, the University of Oklahoma College of Medicine Alumni Association founded the Oklahoma Medical Research Foundation. The dream was to create a foundation associated with the medical center that would foster much-needed research.

The announcement that the Veterans' Administration would build a 1,000-bed hospital on the College of Medicine campus in 1946 is an important part of this history. The VA Dean's Committee was formed the same year. The first VA Hospital used for educating residents was the Will Rogers Station Hospital at Will Rogers Field in Oklahoma City.

In November 1947, Mark R. Everett, PhD, was named Dean of the Medical School and a new era blossomed. Funding of University Hospital and care of the indigent continued to be a major problem. The legislature had attempted to have counties pay for indigent care sent to University Hospital; however, the Supreme Court struck down this plan, stating that indigent health care was the state's obligation. Funding this indigent load would prove to be a difficult fiscal and political issue into the twenty-first century.

During Everett's term as dean, a ten-year plan was developed that included new additions

to University Hospital and capital projects at the medical school.[2] Also, early in Dr. Everett's term, the medical school came off an eleven-year probation by the Council on Medical Education.

Governor Roy Turner was a great supporter of higher education in Oklahoma and an ambassador for development of the medical center. With Governor Turner, President Cross, and Dean Everett in office, much was accomplished. The rural preceptorship was established (1949), and bedside teaching was introduced for the third and fourth years of medical school.

The first half of the 1950s brought significant changes in medical education. The Veterans' Administration Hospital was opened in September 1953, and Stewart G. Wolf, MD, was recruited to be the first full-time chair of internal medicine in 1952. Medical education in the clinical sciences would forever be changed by this paradigm shift in educational philosophy. Ambulatory care for indigents was organized by Dr. John Claremore, with support from grants. This decade showed much progress in research funding as well, led by Dr. Robert Bayley, professor of cardiology, securing NIH funding for his research in electrocardiography.

As Raymond Gary entered the Governor's office in 1954, another funding crisis loomed heavy at the University Hospitals and medical school. A special study in 1955 by the Governor's office showed that University Hospital had fewer teaching beds in operation for 100 medical students in 1955 than they had for 58 medical students in 1952.[2] A supplemental appropriation of $330,000 was made, but was once again only patchwork financing for University Hospital and the care of the indigent.

In 1955, the medical center began to take shape, both physically and organizationally. A master plan was developed that created a 35-block area around University Hospital where private hospitals, the State Health Department, and other health-related colleges would be located. Dr. Everett was named medical center director in addition to being dean of the medical school.

As the 1950s came to an end, the twenty-seventh legislature passed two very important bills for the medical center's future. The first, House Bill 589, authorized an emergency appropriation of $400,000 that enabled a matching federal grant to build the new research building on the medical center campus. This space was badly needed as the faculty, led by Dr. Stewart Wolf, had become quite successful securing grants from the NIH for research purposes. The second was Senate Bill 20, which abolished the Oklahoma Commission for Crippled Children and placed the Children's Hospital in the hands of the Welfare Department under the direction of Lloyd Rader, public welfare commissioner.



Crippled Children's Hospital, constructed in 1928, was also funded by the Oklahoma State Legislature at a cost not to exceed $300,000.

A long-range planning committee for further development of the medical center was named in 1962 with Robert Bird, MD, as its chair. This committee called for the construction of a new $20 million University Hospital. A legacy through a state bond issue was left by Henry Bellmon during his first term as governor in 1963. A $7 million bond issue was passed by Question 411 on the general ballot that year and led to $14 million of federal matching funds to build a new University Hospital. Shortly thereafter, Dr. Everett retired as dean, having served from 1947 to 1964, and capping forty years of service to the university.

James Dennis was named Dean of the College of Medicine in 1965 and served through 1970, during which time he proceeded with the plans for a comprehensive medical center. The major funding effort for the grand design of the medical center was known as the HERO bond issue.[7] This $99.8 million bond issue was passed December 10, 1968. The Medical School Alumni Association, headed by president Ed Calhoon, MD, of Beaver, rallied the state's physicians in support of this very important bond issue.

In 1968, Senator Gene Stipe introduced legislation to open a medical school in Tulsa. After much debate, it was decided to make this a two-year extension of the OU medical school for third- and fourth-year students. Governance, a



The affiliatian af the University Haspital Autharity and Calumbia HCA pravided financial capital that enabled the medical schaal ta build a new ambulatary physicians' building far faculty members. Canstructian an the facility began in May 2000.

concern over the years by the Liaison Committee on Medical Education accrediting body, was decided by having the Dean in Tulsa report to the Executive Dean on the Oklahoma City campus, such that it is clear to the LCME that it is one medical school with obvious lines of reporting. In 1999, the University was able to secure a 60-acre campus at 41st and Yale in Tulsa to serve as the campus for the Tulsa branch of the University of Oklahoma College of Medicine. A grant by the Schusterman family made possible this acquisition.

From 1969 through the early 1970s, financial problems again rained on the medical school—this while much construction was being planned using state bond money, private investment (Dean A. McGee Eye Institute and Presbyterian Hospital), and matching federal funds (University and Children's Hospital). The financial crisis related to operating funds: the teaching hospitals remained under the control of the University; costs were rising; and indigent care was not being reimbursed, or was being reimbursed well below costs. Over the previous ten years, AAMC data revealed operating costs of teaching hospitals had risen 167.2% nationally, while Oklahoma increased its appropriations only 53.3%.[7] To add insult to injury, federal grants were slashed 15% by presidential decree in 1970, creating a funding crisis at the medical school.

The financial crisis of 1971-1973 led to the hiring of a consultant from California (Herman Smith Associates). As absurd as it sounds today, the consultant's solution was to attempt to collect outstanding hospital bills. This was projected to reduce the $3 million annual deficit to $1.7 million.

In 1973, the state legislature transferred the teaching hospitals to the Department of Human Services under the direction of Lloyd Rader. This transfer allowed large sums of money to be infused for capital in the teaching hospitals from 1976 to 1982. Although administration of the hospitals was controversial, the medical school was able to function better during these years because it was rid of the budgetary responsibility of the teaching hospitals.

In 1984, as Oklahoma's revenues fell with the oil bust, the state's institutions of higher education suffered. Once again, the College of Medicine saw a funding crisis. This chronic underfunding was to continue into the present day. However, by the late 1980s, several circumstances came about that allowed the College of Medicine to grow and develop in ways that had not previously been possible.

Private Funding Grows

Beginning in 1985, three important actions led to increased private funding at the College of Medicine and Health Sciences Center.

In 1985, Presbyterian Hospital, which had been built on the Health Center campus in 1974, was sold to Hospital Corporation of American (HCA). HCA paid approximately $60 million for the hospital and donated $65 million to a private foundation in Oklahoma City. This new foundation, a charitable corporation, began business as Presbyterian Health Foundation (PHF). Its board of trustees and chairman of the board, Mr. Stanton L. Young, elected to establish the Oklahoma Health Center and College of Medicine as primary recipients of funds from this foundation; the foundation elected to fund primarily medical education and research in Oklahoma. From 1985 to 2000, the PHF granted approximately $45 million in support of medical education and research to the medical school. These gifts are in the form of research and educational grants and endowed chairs. An additional $22 million was granted to the Health Sciences Center in other colleges.

In 1989, at the time the state legislature passed a bill establishing the endowed chairs program, the University of Oklahoma College of Medicine had approximately $5 million in endowments. In 2000, the College of Medicine has $131 million in endowments. Seventy-seven

million dollars of these gifts have come to the medical school since 1995 under the leadership of Joseph J. Ferretti, PhD, Provost, and David L. Boren, University President.

In 1996, Doug Voth, MD, left the College of Medicine to serve as Dean of the College of Medicine in the United Arab Emirates. Jerry Vannatta, MD, was appointed Dean in 1996, and continues to serve at the present.

New Directions for University and Children's Hospitals

In 1992, health care in America began to change dramatically. As the US Congress rejected the Clinton Health Care Bill, the society elected to let the "marketplace" drive down the cost of health care. The marketplace chose health maintenance organizations (HMO) to accomplish this. States began to convert their fee-for-service Medicaid plans to HMO care. This created competition for academic health centers and medical schools where no competition had previously existed.

Medical schools, and especially teaching hospitals, began to see dramatic losses in revenues. This trend in losses began in 1993 and continues today for a variety of reasons. The University and Children's Hospitals on our campus were already operating on very small margins, and as Medicaid transitioned into HMO care in Oklahoma, hospital revenues plummeted. This began in earnest in 1994 and became worse in 1995. The state legislature passed House Bill 1751 instructing the University Hospital Authority to seek a financial partner. A request for proposals was released, and Columbia HCA (now known as HCA), the company that had in 1985 purchased Presbyterian Hospital, was chosen.

Negotiations began in the summer of 1995 and lasted two years. A document was adopted called the Joint Operating Agreement. This agreement is between the Columbia HCA corporation and the University Hospital Authority; it made the Columbia corporation manager of the hospitals, the employees became Columbia employees, and a ten-member board was formed for governance. Five members of this board are appointed by HCA and five members are appointed by the state of Oklahoma. Indigent care, a long tradition and mission at University and Children's Hospital, was transferred to HCA, who agreed to provide up to 150% of the amount of indigent care appropriated by the legislature. For instance, in 1998 the legislature appropriated $26 million to the hospitals for indigent care. HCA agreed to provide up to 150% of the amount, or $39 million, in indigent care.



Medical students at the Health Sciences Center gather at the new Student Center building that was dedicated in 1995.

The medical school negotiated an Academic Affiliation Agreement (AAA) with Columbia HCA. This agreement is a contract that covers professional services the College of Medicine provides the hospitals. It is governed by a liaison committee, half of whom are state appointees and half appointed by HCA.

The complicated but chronic underfunding of the teaching hospitals had finally led to a solution of finding a private management partner to operate the hospitals. This strategy had the advantage of reducing the costs of governmental administration of the hospitals and the added advantage of well-defined cost accounting of indigent care. The advantage to the medical school was that the agreement brought with it enough capital to build a new ambulatory physicians' building for the faculty. Construction of this building began in May 2000. It also provided for much-needed consolidation of hospital services on the campus that provide operational efficiencies.

In 1997, the medical school was approached by the Donald W. Reynolds Foundation. The Foundation was interested in receiving a proposal from the College of Medicine for them to fund the development of an academic department of Geriatric Medicine. In 1998, the funding was approved at $11.2 million. The department was formed and Marie Bernard, MD, was named as its first chair.

The state regents for higher education joined this effort with additional state funds. Of the



As part of the OUHSC and College of Medicine's strategic plan on research, a new biomedical research center was constructed in 1995.

$11.2 million from the Reynolds Foundation, $11 million will eventually be matched with state money to endow the new department at $22 million. The college plans to provide every third-year medical student with a clerkship in geriatric medicine by 2003. This very important initiative by the Reynolds Foundation will establish the OU College of Medicine as a national leader in geriatric education.

Upon being named President of the University of Oklahoma, David L. Boren began planning for a student center at the Health Sciences Center. It was dedicated in 1995 and serves as a central meeting place for students on campus. Its presence has increased intercollegiate activity and communication, and improved student satisfaction.

Research Funding Expands

Beginning in 1992, the OUHSC and College of Medicine developed a strategic plan for research. Internal budgets were cut to reappropriate money toward areas that were weak. Pediatrics, Biochemistry, and Urology were rebuilt, attracting outstanding chairmen in Terry Stull, MD, Paul Weigel, MD, and Dan Culkin, MD, respectively. Investment in the College's overall research effort included a new research building. This strategic plan resulted in overall research funding increasing 100% from 1993 to 2000, and NIH funding increasing 75% from 1995 to 2000. Among other initiatives, the College of Medicine has applied to the NIH for a $10 million grant to fund a General Clinical Research Center. This center will aid our plan to double clinical research funding over the years 2000-2005.

The University of Oklahoma College of Medicine has a rich and dramatic history. Despite funding from the state below levels of peer institutions, the College has a proud history of educating Oklahoma's physicians. This proud record has been supported through the years by the Oklahoma State Medical Association and the physicians of our state.

The Author

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Medical College Deans at Critical Stages

Edward N. Brandt, Jr., MD, PhD

Introduction

The University of Oklahoma College of Medicine was founded as a two-year school in 1900, seven years before statehood. Indeed, it is the only state medical school founded before statehood. Since its founding and its growth into a four-year MD-granting college beginning in 1912, more than 7,000 physicians received their medical degree from the institution. In addition, with the opening of University Hospital in 1919, residencies were started.

The first resident was Dr. Raymond L. Murdoch who became a distinguished surgeon in Oklahoma City following completion of his one year of training. Since then, numerous physicians have completed residencies in most specialties and gone on to medical careers, most in Oklahoma.

The Beginning

The October 2, 1900, minutes of the Territorial Board of Regents included the following paragraph: "Motion made and seconded that the report of President [David Ross] Boyd be accepted that he had employed Dr. L.N. Upjohn for the Head of the Premedical Department and Director of Physical Culture at a salary of $1,000.00 per year." In addition, Dr. Upjohn was permitted to practice medicine part-time. The courses were equivalent to the preclinical years of an accredited medical school. Following completion, the student could then enroll for the clinical years at other schools and receive the MD degree.

Dr. Lawrence N. Upjohn was born in Michigan in 1873 into a family of physicians. He graduated from the University of Michigan Medical School in 1900, and later that same year became head of the University of Oklahoma College of Medicine. Meanwhile, his father and uncle founded The Upjohn Company. In 1904, Dr. Upjohn left the University to join the family company, rising to become president in 1930 and chairman and CEO in 1943. He was succeeded by his son, E. Gifford Upjohn, MD, in 1952. Dr. L.N. Upjohn was, even in his later years, very curious about the status of the medical school. He died in 1967 at the age of 93.

The curriculum developed and implemented by Dr. Upjohn received a rating of "A" by the national accrediting body, making the graduates of the College of Medicine eligible to enter almost any other American school to complete their MD. He laid an effective foundation for the quality of the school that led to the ease of expanding to a full four-year school in 1900 by essentially taking over the existing Epworth Medical College, which had been unfavorably rated in the AMA study led by Dr. Andrew Flexner.

In the early 1990s, I discussed establishing an endowed chair for the Dean of the Medical School in Dr. Upjohn's honor. I met with his descendents, and in spite of the number of Upjohn physicians who had graduated from the University of Michigan, they agreed to fund the chair. Hence, all Deans from 1990 on are known as Lawrence N. Upjohn Professor and Dean.

A Builder Who Stood Up to Political Power

On May 27, 1915, the State Board of Education appointed LeRoy Long, MD, as Dean. Dr. Long was born in 1869 and received his MD from Louisville Medical College in 1893. After practicing in Atoka and Caddo, he opened a surgical practice in McAlester in 1904. He had been active in organized medicine, having served as Chair of the Indian Territory Medical Board and President of the Indian Territory Medical

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Association from 1900 to 1901. At the time of his appointment, the medical school was in bad condition due to poor funding and neglect by the state government. It had been downgraded by the accrediting agency to a rating of "B," the faculty was demoralized, and there were no full-time clinicians on the faculty. Dr. Long established a surgical practice in Oklahoma City and worked half-time at the school. He was successful in obtaining funds for necessary equipment and a "deficiency" appropriation to strengthen the school with the strong support of Governor Robert L. Williams.

In 1917, House Bill 366 was introduced in the state legislature to appropriate $200,000 for a University Hospital. Although there was some opposition from individual physicians, organized medicine generally supported it, as did Governor Williams. It passed. The funds were obtained from those that had been allocated for building a dome on the state capitol.

With this support, the University Hospital was dedicated in 1919, having experienced construction delays because of World War I. As a result of the funding and the new hospital, in 1920, the rating of the medical school was advanced to "A." In addition to these accomplishments, Dean Long was also able to gain approval for the Medical School Building that opened in 1928, permitting the entire four years to be offered in Oklahoma City, and the Crippled Children's Hospital, which opened that same year. Some of the faculty serving during Dean Long's tenure included James J. Gable, MD, David W. Griffin, MD, Everett S. Lain, MD, John F. Kuhn, MD, Robert M. Howard, MD, A.K. West, MD, Louis Turley, MD, and L.J. Moorman, MD, who succeeded Dr. Long as Dean in 1931.

Although the future was bright for the medical school, a political development caused great conflict. In 1931, William H. ("Alfalfa Bill") Murray became governor and, on July 27, 1931, issued an Executive Order that decreed that chiropractors be allowed to care for patients in University Hospital. A specific patient, Mrs. W.O. Burgett, was mentioned in the order. Dean Long resigned in protest. The Oklahoma State Medical Association (OSMA) and the medical alumni also registered protest. A legal brief prepared for the OSMA said that "cults" could not be admitted legally to the staff of the University Hospital. The Board of Regents upheld the faculty and Dean and ordered that the Executive Order not be obeyed. Governor Murray agreed that the Regents were the final authority, and the crisis passed. However, Dean Long's resignation was not rescinded.

Dean Long's tenure (1915-1931) was one of great progress. Furthermore, by resisting the political power, he demonstrated for all time that the medical school was to be operated to meet the requirements of a "Class A" school.

Unpublished Probation

The College of Medicine was informed in 1936 by the Council on Medical Education and Hospitals, the national accrediting body, that it was now on "unpublished probation" due to inadequate financing and political interference. Furthermore, the Council had required that the class size be reduced from 77 to 65. Apparently there was no response from the College except for the reduction in class size. Jacques P. Gray, MD, was appointed Dean in 1946 and only by accident discovered the accreditation status and poor financial condition of the College. Because of an inability to make progress in addressing these issues, he resigned in 1947. However, two important events did occur in that year. First, the medical alumni association was successful in establishing the Oklahoma Medical Research Foundation (OMRF); and second, the alumni and the medical profession were able to obtain funding for the Oklahoma City Veterans Administration (VA) Hospital. Both of these institutions became part of the campus.

On November 10, 1947, President Cross announced the appointment of Mark R. Everett, PhD, as Dean. Dr. Everett had served as Professor and Chair of the Department of Biochemistry since 1924. Dr. Everett was a native of Pennsylvania who had obtained his PhD degree in biochemistry from Harvard University in 1924. He joined the faculty of the University of Oklahoma School of Medicine that same year. He was an active investigator and had published frequently in scientific journals. He retired from the Deanship in 1964.

Although reluctant to serve as Dean, Dr. Everett immediately went to work on the accreditation deficiencies. He was able to obtain additional funds from the State Regents for Higher Education and obtain additional beds for teaching purposes via affiliation with Wesley, Mercy, St. Anthony, and VA hospitals. He reorganized the faculty, especially in the clinical departments. As a result, the School was removed from probation in 1948. The election of Governor Roy J. Turner in 1949 was quite positive for the medical school and, indeed, for all of higher education. The Governor led the effort to increase state appropriations and was successful in doing so.

Meanwhile, the rural preceptorship was started, and there was pressure to increase the class size to 100 entering students. However, there was still concern expressed by the accreditation body that there were no full-time clinical faculty except for Dr. Robert H. Bayley, who was primarily an investigator. Dr. Bayley made significant contributions to our understanding of electrocardiography. In 1952, Dean Everett was successful in hiring Dr. Stewart G. Wolf as Chairman of Medicine, and he brought Dr. Robert M. Bird as Vice-Chair. Later, they were joined by Drs. John Colmore and William Schottstaedt. Several years later, Dr. L. Jolyon West was appointed Chair of Psychiatry, followed by Dr. John Schilling as Chair of Surgery. Dr. Schilling also recruited Dr. Merlin K. Duval and Dr. G. Rainey Williams.

When Dr. Everett retired from the Deanship in 1964, the School was in good shape, although most of the faculty were generating their own salaries and those of their assistants through federal and private grants. Dr. Everett assumed the role of Regents Professor and spent the remainder of his days writing the definitive history of the Medical School from 1900-1964, on which many of the details of this article are based.

The Dreamer

James L. Dennis was born and raised in Britton, Oklahoma, then a separate community. He completed his pre-medical requirements at Central State Teachers College and received his BS and MD degrees from the University of Oklahoma College of Medicine in 1940. After training in pediatrics and a distinguished career in California and Arkansas, he was appointed Dean of the Medical School, Director of the Medical Center, and Professor in 1964. He was the first person to serve as Dean who had received an MD degree from the University of Oklahoma.

Upon arriving in Oklahoma City, he evaluated the strengths and weaknesses of the Medical School and the Medical Center. He began to visualize a total health sciences campus modeled after the Texas Medical Center that would involve expansion of the University programs plus attraction of private hospitals and clinics to the campus. Working with civic leaders in Oklahoma City including such people as Stanton Young, Dean McGee, and others, and with state government, especially Governor Henry Bellmon, he was influential in developing a plan that was acceptable to the public, the state, and the academic community. With this plan, the voters of the state passed the HERO (Health Education for a Richer Oklahoma) bond issue in 1968. The bond funds would be matched with federal funding for new construction, new schools, and equipment. As a result, the campus of what is now known as the Oklahoma Health Center began to take form, and construction began quickly on the Basic Science Education Building (the first new building to be opened), the University Hospital, and the Robert M. Bird Library. In addition, Schools of Allied Health and Public Health were founded. Dr. Dennis and Dr. John Holliman, President of the University, begin to clash over the future of the Health Center, leading to Dr. Dennis's resignation in 1970. He returned to the University of Arkansas as Vice-President for Health Sciences and Professor of Pediatrics. He retired from those positions in 1981.

At the time of his appointment in 1964, the Medical School was struggling financially. It was heavily dependent on federal grant funds for faculty salaries and was not looked upon favorably by the community and state. During his tenure, the reputation of the Health Center grew and gained respect among the populace. All in all, his dream and his ability to choose outstanding people such as Drs. Merlin Duval, Robert Bird, and Joseph White to implement his ideas resulted in a stronger school and a greatly expanded complex. Without his leadership and the support of the civic leaders and the governor, it is doubtful that the Oklahoma Health Center with its multiple institutions and activities would exist.

Summary

Throughout its 100-year existence, the College of Medicine has faced numerous crises, mostly due to inadequate funding. Furthermore, at various times there has been significant political interference, the worst of which was the Executive Order issued by Governor William H. Murray. However, these four Deans exhibited great leadership during especially difficult times. In several instances, they were aided by sympathetic and effective Governors including Robert L. Williams, Roy S. Turner, and Henry Bellmon. The College of Medicine was fortunate that they were willing to proceed through adverse conditions, because without them, many of us would not have had the opportunity to attend medical school in Oklahoma. ∎

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SPECIAL

The History of Electrocardiology and Electrophysiology at the University of Oklahoma

Ralph Lazzara, MD

For more than fifty years, the University of Oklahoma Medical Center has had a prominent place in the medical sciences related to electrical activity of the heart. The first step was a giant step: the recruitment of Robert H. (Bill) Bayley from Louisiana State University in 1944. Dr. Bayley had trained at the University of Michigan under the mentorship of F. N. Wilson, who introduced the V leads and the central terminal to electrocardiography and was considered the premiere scientist of electrocardiography of his time. Dr. Wilson's approach was both experimental and theoretical/mathematical, and Dr. Bayley carried on this scientific style throughout his career.

When Dr. Bayley arrived as professor of medicine and director of the Heart Station, he was one of a small number of full-time faculty in the clinical departments, and the first full-time faculty member in the Department of Medicine. Because the medical school followed certain European models, Dr. Bayley was the only full professor who was not a department chair until the 1960s when more full professors were appointed. Displaced from his office in the University Hospital in 1952 by the first full time chair of the Department of Medicine, Dr. Stewart Wolf, Dr. Bayley had his offices and laboratories in a house on 13th Street, a site that is now part of the grounds of Presbyterian Hospital. Ironically, this eminent investigator in the electrocardiography of coronary artery disease suffered a myocardial infarction while he was at the University Hospital that he diagnosed himself from his own electrocardiogram. He was disinterested in the administrative hierarchy and remained predominantly involved in research until his death in 1969 during surgery for an abdominal aortic aneurysm.

Throughout his 25-year career at the University of Oklahoma, he regularly published important papers dealing with both the theory and practice of electrocardiography, especially as related to ischemia and infarction. His research into the theory of electrocardiography employed sophisticated volume conductor models and mathematical analysis and overlapped into the related fields of vectorcardiography and body surface mapping. His studies of ischemia and infarction used experimental animals and patients. A whimsical example of his experimental creativity was his immersion of "volunteer" medical students wearing diving masks in a copper bell to test fundamental theories of electrocardiography and vectorcardiography.

Studies in experimental animals by Dr. Bayley and his coworkers, including Dr. Safety First, provided evidence that conduction of the electrical impulse in the surviving myocardium adjacent to an infarct was abnormally slow and delayed. They coined the expression "peri-infarction block" in 1950,[1] which came into widespread use in electrocardiography. This concept has been the basis for studies by many investigators implicating abnormal conduction in the myocardium bordering an infarct as a site for arrhythmia generation and for the generation of "late potentials" recorded in high resolution electrocardiography to predict arrhythmia risk.[2] It has therapeutic relevance even today in the application of radiofrequency catheter ablation to eliminate slow-conducting regions of myocardium in and around infarcts to abolish ventricular tachycardia associated with myocardial infarction.

The excellence of Dr. Bayley's research was recognized by multiple sizable grants from the National Institutes of Health. He was one of the

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first recipients of the Established Investigator Award of the American Heart Association and a member of the first Research Committee of the American Heart Association. In 1959, he received a citation from the American Heart Association for distinguished service to its research program. He was one of the few people appointed an Honorary Fellow in the American College of Cardiology. He was a founding member of the Southern Society of Clinical Investigation. He was a George Lynn Cross Research Professor at the University of Oklahoma and a member of the Oklahoma Hall of Fame. When he died, a symposium dedicated to him was held in Oklahoma City and an obituary, invited by the editor Dr. George Burch, was published in the *American Heart Journal*.

Cardiologists prominent in Oklahoma who were among Dr. Bayley's protégés include Dr. L. L. (Lee) Conrad, Dr. Safety First, Dr. Wylie McCollum, and Dr. John Kalbfliesch. Dr. Lee Conrad spearheaded, along with Dr. Charles Robinson, the first remote monitoring system in the country by which patients in the VA Hospital in Muskogee were monitored at University Hospital in Oklahoma City. The network was extended and networks were established from Presbyterian Hospital in Oklahoma City by Dr. Robinson and from St. Francis Hospital in Tulsa by Dr. Kalbfliesch.

Dr. Ed Brandt, now Regents Professor and Chair of the Department of Health Administration and Policy, was a mathematician teaching in the Mathematics Department at the University of Oklahoma in Norman before entering medical school. He was enlisted as a medical student to conduct teaching sessions for medical faculty and became closely linked to Dr. Bayley and his group, teaching them principles of vector analysis that they used in their research and in their manuscripts.

After Dr. Bayley's death, research in electrocardiography languished at the University of Oklahoma. However, in 1974, Dr. Eliot Schechter joined the faculty and brought an interest in the new discipline of clinical electrophysiology, in which electrode catheters are used to stimulate and record directly from the heart to diagnose and guide therapy for arrhythmias. These procedures, called electrophysiological studies, were first applied at the Health Sciences Center in the mid-1970s. A future faculty member at the University of Oklahoma, Dr. Ben Scherlag, was one of the founders of this field by developing techniques for recording via catheters electrical activity from the heart with great precision.[3]

A new era of notoriety for the University of Oklahoma in electrical affairs of the heart began in 1978. Dr. Ralph Lazzara was recruited by Dr. Solomon Papper, Chair of the Department of Medicine, to direct the section on cardiovascular diseases at the University of Oklahoma. Dr. Lazzara had been acquiring expertise and knowledge in basic electrophysiology and arrhythmia management since 1964, when he had spent a special fellowship in the renowned laboratories of Dr. Brian F. Hoffman in the Department of Pharmacology at Columbia College of Physicians and Surgeons in New York. Between 1970 and 1978, at the University of Miami as director of the electrophysiology laboratories at Mt. Sinai Medical Center (1970-1972), and as director of the Coronary Care Unit and Chief of Cardiology at the Miami VAMC (1972-1978), he gathered a team of basic scientists, engineers, and physicians that performed extensive studies in experimental animals and patients to clarify the electrical abnormalities that underlie cardiac arrhythmias, especially in coronary artery disease. Coronary artery disease is the most common cause of serious arrhythmias and the most common condition associated with sudden arrhythmic death. During the Miami period, the work of these investigators produced more than 60 manuscripts and valuable insights into the mechanisms of arrhythmias and antiarrhythmic drug actions.

A new type of electrocardiogram was developed, called the signal-averaged (high resolution) electrocardiogram.[4] This technique extended the recording fidelity of the electrocardiogram by a factor of 1,000, allowing the recording of microvolt (one-millionth of one volt) potentials rather than millivolt (one-thousandth of one volt). This had been a goal of Dr. Bayley more than three decades before. This group also followed Dr. Bayley's lead in studying the abnormal tissues surrounding an infarct and identified these tissues as being critical in the generation of arrhythmias.

Dr. Lazzara brought members of that team to the University of Oklahoma in 1978, including Dr. Ben Scherlag, a basic scientist, and Dr. Ron Hope, a cardiologist now practicing in Oklahoma City. Dr. Ed Berbari, the engineer in the group who developed signal-averaged electrocardiography, came to OU in 1981 after an interlude in which he received his PhD. He remained at the University of Oklahoma until 1994, extending the studies and application of signal-averaged electrocardiography that became a worldwide tool. He has been a prolific investigator, clarifying the mechanisms of arrhythmias and antiar-

rhythmic drug action. Dr. Dwight Reynolds came to the University of Oklahoma in 1980 and developed an expertise in cardiac pacing that has been internationally recognized. He has contributed many chapters to major textbooks in this field. Dr. Warren Jackman came to the University of Oklahoma in 1982 and now serves as director of the clinical electrophysiology program and co-director of the Cardiac Arrhythmia Research Institute. Dr. Eugene Patterson, a pharmacologist, came to the University of Oklahoma in 1983 initially as a post-graduate student and remained on faculty, and is now in the Department of Cell Biology. Dr. Lazzara resigned as chief of cardiology in 1998 after 20 years in that position, and now is the director of the Cardiac Arrhythmia Research Institute at the University of Oklahoma.

In the 22 years since 1978, the group of basic scientists, engineers, electrophysiologists, and device specialists has published extensively (more than 300 manuscripts and book chapters) and attracted the attention of the world to the University of Oklahoma and its arrhythmia program. Many research and clinical trainees and practicing and academic physicians have visited the basic and clinical laboratories at the University of Oklahoma.

In the late 1980s, a startling development occurred: the procedure of radiofrequency catheter ablation to cure cardiac arrhythmias. Clinician-scientists at the University of Oklahoma Health Sciences Center, led by Dr. Warren Jackman, are recognized as leaders and pioneers in the field and the premiere practitioners of this discipline. The original reports of cures of the two common types of paroxysmal supraventricular tachycardia were published in *The New England Journal of Medicine*[5,6] and generated excitement worldwide. The news was broadcast widely in the media, including reports in the *New York Times* and syndicated articles from Associated Press that were published from Savannah to Los Angeles. Physicians of the world beat a path to the door of the University of Oklahoma to witness this better mousetrap. Patients were referred to Dr. Jackman from all over the United States and the world; the waiting period was months. Most patients referred have had this procedure attempted and failed by capable electrophysiologists elsewhere. Dr. Jackman serves as a resource of last resort for the entire nation.

Multiple major awards have recognized contributions of the OU faculty to the field of electrophysiology and arrhythmias. Dr. Scherlag's place as a founder of the field of clinical electrophysiology was established when he received the Pioneer in Pacing and Electrophysiology award from the North American Society of Pacing and Electrophysiology (NASPE) for developing the technique of recording the electrogram of the tiny structure, the His bundle, with a catheder. NASPE is recognized as the premiere scholarly society in the world for the field of cardiac electrophysiology, pacing, and arrhythmias. Dr. Scherlag's paper on His bundle recording was listed in Citation Classics, a compilation of the most-cited manuscripts in the literature. Dr. Jackman received the Pioneer in Pacing and Electrophysiology award of NASPE this year (2000) in recognition of his momentous contribution to the discipline of radiofrequency ablation for the cure of cardiac arrhythmias. Dr. Lazzara served as President of NASPE (1995-1996) and received the Distinguished Scientist award in 1999. He also received the Paul Dudley White award of the Association of Military Surgeons in 1990.

To assure the University of Oklahoma's continuing preeminence in matters related to the electrical activity of the heart, a new institute has been formed, the Cardiac Arrhythmia Research Institute. Its purpose is to unite in one area of University Hospital all faculty with a primary interest in electrophysiology and arrhythmias, including basic scientists, engineers, and clinicians, to facilitate communication and collaboration and enhance progress in research. Its mission is to find cures for arrhythmias through teaching and education, and it has been approved as a Center of Excellence by the Office of the Provost. Dr. Lazzara is the first director and Dr. Jackman is the co-director of this new institute.

The Author

Ralph Lazzara, MD, is George Lynn Cross Research Professor and Natalie O. Warren Professor of Medicine and Director of the Cardiac Arrhythmia Research Institute at the University of Oklahoma.

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Caring for Oklahoma's Children: The Department of Pediatrics and Children's Hospital of Oklahoma

Sana Srouji Rettig; Terrence L. Stull, MD

The University of Oklahoma Department of Pediatrics was founded in 1930. Its history has mirrored the cyclic history of the state's economic development. The Department has maintained its commitment as a central resource for specialty care for sick children, training future physicians, and creating new information to improve children's health. The Department is currently in a stage of growth based on support from the College of Medicine and the community. Because the histories of the Department and the Children's Hospital of Oklahoma are intertwined, this article gives an overview of each.

The Early Years

One of President William Bizzell's major accomplishments as President of the University of Oklahoma during the mid-1920s was the development of the University's Medical Center. President Bizzell was committed to building the Hospital for Crippled Children and to moving the medical school building from Norman to the Oklahoma City campus. In 1927, two years after he took office, the eleventh Oklahoma legislature passed bills to construct the Hospital for Crippled Children under the direction of the University Hospital Authority. Enactment of the bills was largely due to Governor Henry Johnston who delivered a special message to the legislature requesting that a hospital for crippled children be built in Oklahoma City. Subsequently, Senate Bill 75 was approved on February 18, 1927, for the State Board of Affairs to build and equip such a hospital.[1] The bill provided that the cost of the hospital was not to exceed $300,000, the actual amount appropriated. At the same time that Governor Johnston signed the bills authorizing construction, Lew Wentz, a philanthropist and influential supporter of the bill from Ponca City, donated funds to build the Crippled Children's School adjacent to the hospital to supplement the children's schooling when hospitalized for several weeks or months.

The Hospital for Crippled Children, a three-story building with a capacity of 160 beds and a final total cost of approximately $414,000, was constructed at NE 13th Street and Kelley Avenue.[1] It was completed in October of 1928. As principal speaker at the dedication ceremony on November 2, Governor Johnston emphasized the principles of the medical profession and the appeal of the crippled child to the public.

As soon as it was built, the Hospital for Crippled Children became the center for medical and surgical care of children, as well as a center for many statewide aspects of healthcare for children. Community efforts towards that end, in cooperation with the School of Medicine, began to appear throughout the state. The most active community organization of this nature was the Oklahoma Society for Crippled Children. Individuals like Lew Wentz represented the great community leaders speaking on behalf of children. Joe Hamilton was also a very committed, capable, and inspired member of the Oklahoma Society for Crippled Children who, together with Wentz, secured passage of the bills mentioned, and who greatly influenced state health matters affecting children at that time.[1] At its very beginning, the Department of Pediatrics was closely connected with the community's interest in children's healthcare.

Administration and operation of the Hospital

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for Crippled Children at that time was largely under the control of the Department of Orthopedics. Seven faculty members in the Department of Medicine, including Dr. William Taylor, held titles related to the subject of pediatrics. Pediatrics became a separate department of the medical school in 1930 with Dr. Taylor as its chair. That same year Dr. George Garrison was appointed instructor in pediatrics; the Hospital for Crippled Children had expanded to 200 beds and recorded 2,907 admissions; and the Department of Social Work began to function in the hospital.[2] When Dr. Taylor retired as head of the department in 1938, Dr. Clark Hall succeeded him for the next decade until the arrival of Dr. Henry Strenge, the first full-time head of the department, in 1947. The 1940s were a difficult period of budget constraints due to World War II. However, Dr. Strenge and Dr. Theodore Pfundt, acting chairman from 1957-1958, maintained Pediatrics as an active department. Dr. Harris D. Riley, Jr. arrived as chair in 1958.[3]

It is important to note that during those early years of the Department's existence, several community pediatricians played key roles in the teaching mission of the department as part-time faculty members. In addition to Dr. Garrison, who supervised the pediatric clerkship and whose medical practice spanned over 50 years in Oklahoma City, Drs. Ben Nicholson and Charles Bielstein were major supporters of the department and the hospital.[3]

The Riley/Rader Era

When Dr. Riley arrived in 1958 from Vanderbilt University as Professor and Chair of Pediatrics, the department consisted of one full-time faculty member, two part-time physicians, and one house officer. Under his direction, the department grew to almost 60 full-time faculty members with residents, fellows, and subspecialty units in several sections of the department. During his chairmanship, the department established the infectious disease laboratory, the birth defects center, the Child Study Center, a pediatric pharmacology unit, the first division of children's psychology in pediatrics, the NIH-funded Pediatric Clinical Research Center, and the Cystic Fibrosis Research Center. Training opportunities in the field of general pediatrics and pediatric subspecialties became available and were well-respected. The program offered residents a well-rounded experience in the broad field of pediatrics and the opportunity for concentrated work in a subspecialty field or research area in the form of fellowships. Physicians in various medical and surgical specialties conducted the teaching. Pediatric faculty made up the medical teaching team while members from the Departments of Surgery, Urology, Radiology, and Neurology provided the surgical training. Most of the pediatricians practicing in Oklahoma City and its suburbs participated in the teaching program at Children's Hospital, and some came from other communities. The adjacent University Hospital housed the newborn nursery and premature service, later to become the Neonatal Intensive Care Unit. Thus, under Dr. Riley's leadership, the department was elevated to one of national significance and recognition.

The decades of the 1960s and 1970s also saw growth in the School of Medicine's research activities and grant funding. The National Institutes of Health supplemented a good portion of the medical center's activities, including those of the Department of Pediatrics.[4] By 1963, gifts and grants for research and training programs to the campus had reached an all-time high of approximately $4 million, mostly from federal funds. The bulk of these restricted funds were distributed to nine departments, including Pediatrics.[2] The next year, this amount was increased by another million, thus indicating the productivity and growth of the faculty members. The hospital's programs were also supported by community organizations such as the Junior League of Oklahoma City and the Junior Hospitality Club. Individuals and community groups funded programs and equipment purchases. The Department joined with other teaching hospitals to form the Southwest Cancer Chemotherapy Study Group after establishing a new outpatient tumor clinic. The first pediatric renal transplant program in the state was established by Dr. Donald Halverstadt in 1971. A modern pediatric cardiopulmonary diagnostic laboratory was established under the direction of Dr. Webb Thompson.

The Oklahoma medical center experienced the end of an era in 1964 when Dr. Mark Everett retired after 40 years of service to the medical community, including 17 years as dean of the University of Oklahoma School of Medicine. Dr. James Dennis, Professor of Pediatrics from the University of Arkansas and a graduate of the Oklahoma School of Medicine, assumed the dual post of Dean of the School of Medicine and Director of the OU Medical Center in September of that year. George Lynn Cross was president of the University at the time, and remained in the post until 1968. Over the next 20 years, the Oklahoma Health Center devel-

oped from 3 institutions, 3 schools, and 900 students in 8 buildings on 24 acres to 12 institutions, 7 colleges, and more than 3,000 students in 34 buildings on 200 acres. In addition to maintaining and operating hospitals for the purpose of training and research, one of the medical center's basic functions since its establishment was to "provide hospitalization for the indigent poor, emergency cases, obstetrical patients that are public charges..."; Children's Hospital was operated as "a service institution for the physically handicapped and as a teaching hospital."[4] Thus it was not surprising that the University institutions were perceived as charity hospitals for so long.

The 1970s brought the need for building a new children's hospital. Lloyd Rader, Director of the Department of Institutions, Social and Rehabilitative Services, later to become Department of Human Services, shared that vision and was able to finance it when the legislature approved the transfer of Children's Hospital from the University's stewardship to the welfare department in April 1973. By July, plans for the remodeling and expansion of the children's hospital, including clinics and an emergency room, were underway.[4] The core current building consists of three towers honoring Drs. Bielstein, Garrison, and Nicholson and was named Oklahoma Children's Memorial Hospital upon completion in 1979.

The expansion of Children's Hospital moved rapidly with the remodeling of old facilities and construction of new buildings. One such facility was the Child Study Center, which was originally conceived as a center for exceptional children, with activities directed toward the problem of mental retardation in children at all levels. It grew to provide comprehensive care for children with special needs and to teach developmental and behavioral concepts in pediatrics. There have been recent changes in both the structure and the governance of Children's Hospital. An addition that houses the Jimmy Everest Cancer Center, the Don Halverstadt Urology Center, and the orthopedic clinic was completed in 1996. Management of the University and Children's Hospital was transferred to Columbia in 1998.

1970s and 1980s

In 1976 Dr. Riley resigned as chair of the pediatrics department and Dr. James Wenzl, Professor of Pediatrics and Chief of the Nephrology Service, headed the department as interim chairman until the arrival of Dr. Owen Rennert from the University of Florida in September of 1977. Dr. Rennert served as chair of the Department of Pediatrics for the next decade, including the period of economic hardships that affected all aspects of the state and the Health Center. The late 1970s brought more construction and an eruption of new and modern buildings on the Health Sciences campus. New Schools of Dentistry, Pharmacy, and Nursing, as well as a Biomedical Sciences Building housing the College of Medicine and its research facilities, were built. Until the spring of 1982, the Oklahoma Health Center institutions were thriving, and the state in general witnessed an economic boom triggered by the oil and gas industry. However, less than a year later the industry imploded. The heavy economic blow caused the fall of Penn Square Bank, the costliest bank failure in US history, resulting in a further decline of the state's valued sources of oil and gas, as well as agriculture.[4] The recession resulted in less support for health care and education, and academic and clinical programs at the Health Sciences Center suffered. The faltering economy caused the loss of faculty members across campus; seven valued members of the pediatric faculty left to accept positions elsewhere during 1985 and 1986. Despite the difficulties and shortfalls, Dr. Rennert's period was marked by academic excellence. During the decade that he was chair, the Department of Pediatrics developed unique programs in children's healthcare for the state of Oklahoma, including the comprehensive evaluation and treatment of heart disease, pediatric intensive care, new methods for the treatment of viral and infectious diseases, and unique services for the diagnosis and treatment of birth defects and biochemical genetic diseases. Sub-specialty fellowship programs in the different sections of the Department of Pediatrics trained numerous fellows, many of whom now hold academic positions across the country.

A Time of Transition

When Dr. Rennert resigned as head of the Department in 1988, Dr. James Wenzl once again efficiently maintained the department as interim chair until the 1990 arrival of Dr. Alfred Brann from Emory University. Dr. Brann remained as head for three years, during which time there was a successful rejuvenation of the residency training program. However, the Department lost more faculty members, including faculty leaders, and revenues from clinical income, grants, and contracts declined significantly.

The Present and the Future

Dr. John Grunow became interim chair following Dr. Brann's departure in 1993 and sustained a cohesive and viable department until the arrival in July 1994 of Dr. Terrence Stull as Hobbs-Recknagel Professor and Chairman of Pediatrics from the Department of Pediatrics at the Medical College of Pennsylvania in Philadelphia. The late 1990s were spent rebuilding the department as a competitive academic program in children's healthcare. Funds from the community organization Children's Medical Research Institute (CMRI) and other committed community leaders were matched by the state's Endowed Chairs Program to develop a series of Endowed Chairs in the department. Recruiting a group of pediatric leaders, based on the Endowed Chairs, filled important gaps in the department leadership.

Dr. James Royall, the C.R. Anthony Endowed Chair, was recruited as chief of Pulmonology from the University of Iowa. Dr. William Meyer, the Ben Johnson Endowed Chair in Hematology/Oncology, was recruited from St. Jude Research Hospital, and he has established a pediatric bone marrow transplant program. Dr. John Mulvihill, the Kimberley V. Talley Endowed Chair, was recruited from Pittsburgh and has recruited two other geneticists. Most recently, Dr. Kenneth Copeland was selected as the Jonas Professor of Pediatrics, Chief of the Division of Diabetes/Endocrinology and Vice-Chair of Pediatrics in September 1999. Dr. Copeland was formerly Professor of Pediatrics at Baylor College of Medicine in Houston and Director of the Diabetes Care Center at Texas Children's Hospital in Houston. Other recruitments in progress, also under CMRI's Endowed Chair Program, include the Reba McEntire Chair in Neonatal/Perinatal Medicine, the Shaun Walters Chair in Neurodevelopmental and Behavioral Pediatrics, and the Jean Gumerson Chair in Clinical Child Psychology. In addition, the following Chairs are being actively developed by CMRI:

- The Walton Chair in Pediatric Nephrology;
- The Lewallen Chair in Pediatric Hematology/Oncology;
- The Murcer Chair in Pediatric Hematology/Oncology;
- The Milburn Chair in Pediatric Surgery; and
- The Harris D. Riley Chair in Pediatric Graduate Medical Education.

Recruitment of the above-mentioned, nationally recognized pediatricians to Oklahoma was a collaborative effort that involved significant resources from Children's Medical Research Institute, the College of Medicine, Children's Hospital, Presbyterian Health Foundation, and the state government.

The core training program for the Department of Pediatrics continues to be the Pediatrics Residency Program, with an average of 11 PL-1s and 4 MP-1s (Medicine/Pediatrics) accepted into the programs each year. The Pediatric clerkships during the third- and fourth-year medical curriculum are among the most successful and popular among students. Faculty receiving the Aesculapian Award from medical students for outstanding teaching have been selected from Pediatrics for the last five years in a row. The Department also is responsible for training experiences of Family Medicine residents and residents from the programs of Hillcrest and St. Anthony hospitals. Additionally, students from the Physician Assistant program rotate through Pediatrics. Fellowship programs have recently been reduced but accredited curricula continue to exist in a number of sections of the Department.

In the past five years, the Department has undergone substantial changes and successfully addressed challenges of a market-oriented clinical enterprise as a foundation for its teaching and research missions. Although the changes have altered the traditional academic activities of its members, the Department of Pediatrics has thrived. The teaching programs are highly regarded, and the clinical services continue to grow. In partnering with Children's Medical Research Institute and campus organizations, research for children in Oklahoma is also thriving. The recent growth is a confirmation of the strong foundation lain in the earlier years of the Department of Pediatrics. J

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Full-Time Clinical Department Chairs: Time of Transition

M. Dewayne Andrews, MD

By the early 1950s, medical schools across the United States were in a state of major transition. Significant growth in full-time faculty and full-time clinical department chairs heralded dramatic changes in medical education and clinical research that would change American medicine. This article is a brief summary of the appointment of the first full-time chairs of clinical departments in the University of Oklahoma College of Medicine, focusing on the critical period from 1952 to 1961.

From the beginning of the University of Oklahoma College of Medicine until the early 1950s, leadership of the clinical departments was in the hands of community physicians committed to medical education who served on a part-time basis as faculty and chairs of departments. These pioneering physicians dedicated time, energy, and hard work to sustaining the clinical education program and developing the early residency training programs. Without the efforts of these devoted physicians, the medical school would not have enjoyed its later growth and success.

After World War II, the nation's medical education system began to experience dramatic changes and expansion. Growing demands to organize the activity of clinical departments and develop clinical research made it increasingly difficult for part-time faculty and chairs to sustain leadership positions. Medical schools across the country were acquiring increasing numbers of full-time faculty at a rapid pace. At the same time, the Liaison Committee on Medical Education, the national accrediting body for medical education, was critical of Oklahoma's medical school for its lack of full-time clinical faculty.

By 1951, it was abundantly clear that the college would need full-time clinical faculty and full-time chairs of its clinical departments in order to develop its full potential and remain accredited. Dean Mark R. Everett was determined to take the actions required to ensure continuing accreditation of the medical school. This paper briefly reviews the individuals who came as the first full-time chairs of the clinical departments, focusing on the period from 1952 to 1961—a significant time of transition for the University of Oklahoma College of Medicine.

On April 15, 1952, a significant change in Oklahoma's medical school occurred when Stewart G. Wolf, Jr., was appointed as the first full-time professor and chair of the Department of Medicine. Dr. Wolf received his MD in 1938 from Johns Hopkins University and subsequently took his residency training at the New York Hospital. At the time of his appointment to the University of Oklahoma, Wolf was an associate professor of medicine at the Cornell University Medical School in New York City, where he had already distinguished himself early in his career. Dr. Wolf's appointment also included designation as head of the neuroscience section of the Oklahoma Medical Research Foundation.

Recruitment of Dr. Stewart Wolf to Oklahoma proved to be a signal event. A dynamic leader with charismatic style, he in turn recruited excellent full-time faculty to the department and was influential in the development of other departments. The Department of Medicine was beginning to attract national attention. One of the most important individuals he recruited was Robert M. Bird, MD, who later became Dean of the college, and in whose honor the Health Sciences Center library was named.

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Dr. Wolf had a profound impact on students and residents in internal medicine, stimulating a number of them in scholarly pursuits and academic careers. He was also involved with the civic community and made a favorable impact with influential citizens for the medical school. Wolf served as chair of the Department of Medicine until 1967, following which he moved to the Oklahoma Medical Research Foundation. In 1970, Wolf left Oklahoma to become Director of the Marine Biomedical Institute and Professor of Internal Medicine at the University of Texas in Galveston.

In 1953-1954, University of Oklahoma president George Lynn Cross appointed a long-range planning committee for the medical school. The committee was headed by Stewart Wolf. This committee's work exerted considerable influence on the future direction of the medical school. In its report issued in May 1954, the committee made several important recommendations. One was that it be the policy of the University to provide full-time department heads and a nucleus of full-time teachers for each of the major clinical departments. The University's Board of Regents approved this plan, setting the stage for a new era in the development of the medical school.

The next full-time chair was Louis Jolyon West, MD, in the Department of Psychiatry, appointed in September 1954. A psychiatry ward had been opened in a new addition to University Hospital making full-time leadership of the department even more important. West received his MD degree from the University of Minnesota in 1948. Following medical internship at the University Hospital in Minneapolis, he was a resident in psychiatry at the Cornell Medical Center in New York City. Prior to joining the faculty in Oklahoma City, Dr. West was Chief of the Psychiatry Service at Lackland Air Force Base in San Antonio, Texas. With his appointment, West requested that the name of the department be changed to the Department of Psychiatry, Neurology, and Behavioral Sciences. He served as professor and chairman of the department from 1954 to 1969.

As an educator, Dr. West is best known for the systematic inclusion of behavioral sciences into medical education and for heading psychiatry into the mainstream of scientific medicine. West also recruited many full-time faculty, reorganized services, and established a research base. Two of his key appointments were Oscar Parsons, PhD, and Gordon H. Deckert, MD, each of whom had a distinguished career at the medical school. In 1969, West left Oklahoma to become the chair of psychiatry at UCLA, a position he held for twenty years.

John A. Schilling, MD, was appointed the first full-time professor and chairman of the Department of Surgery on July 1, 1956. Schilling received his MD from the Harvard Medical School and took his residency in surgery at the Roosevelt Hospital in New York City. Dr. Schilling was on the faculty of the University of Rochester School of Medicine and Dentistry when he was recruited to join the faculty at Oklahoma. He built a distinguished department, bringing national attention to the school and medical center. Schilling recruited Drs. Merlin K. DuVal, Jr., Rene Menguy, Gilbert Campbell, and G. Rainey Williams to OU's medical school. Each of these men was a Markle scholar and each became nationally known for a distinguished career. Schilling served as chairman until May 1974, leaving for the University of Washington in Seattle. The first fully endowed chair in the College of Medicine was established in honor of Dr. Schilling, and Dr. G. Rainey Williams succeeded Schilling as the chair of the Department of Surgery.

On August 1, 1956, Joseph M. White, MD, was named as the first full-time professor and chair of the Department of Anesthesiology. White was quickly recognized for his leadership skills. In addition to his academic work in anesthesiology, he also served as acting dean and acting director of the medical center during the interval between deans Mark R. Everett and James L. Dennis. White served as chair of anesthesiology until 1965, when he left for the University of Texas Medical Branch in Galveston.

On March 1, 1957, Gus R. Ridings, MD, was named the first full-time professor and chair of the Department of Radiology. Ridings had been at the University of Mississippi Medical Center before coming to Oklahoma. He struggled with complete reorganization of the radiology department and the pressing equipment needs for the University Hospital. Ridings served until December 31, 1962 and was succeeded by Dr. Sidney P. Traub.

Harris D. Riley, Jr., MD, became the first full-time professor and chair of the Department of Pediatrics on January 1, 1958. Riley received his MD from the Vanderbilt University School of Medicine in 1948 and trained successively at Baltimore City Hospital, Babies and Children's Hospital of Cleveland, and the Vanderbilt University Hospital. Dr. Riley recruited a

respected cadre of full-time faculty and was responsible for initiating many new programs at the Children's Hospital. He was influential in developing a number of innovative programs in children's health care, and he fostered a scholarly environment. Riley served as chair of Pediatrics until January 1976.

Prior to 1961, gynecology and obstetrics operated as separate departments. On April 13, 1961, the University Regents combined them into a single department and named James A. Merrill, MD, as the first full-time professor and chair of the Department of Gynecology and Obstetrics. Merrill received his MD from the University of California in 1948 and completed various aspects of his training in San Francisco, Cleveland, and Boston. Merrill was a colorful, forceful, and highly respected chair who brought many changes to the department and contributed significantly on the national scene. He served as chair of the department until June 1982.

In the three years following 1961, there was continual growth and development of all the clinical departments, and more came to be led by full-time chairs, including: Urology, chaired by William L. Parry, MD (1962); Otorhinolaryngology, chaired by James B. Snow, Jr., MD (1964); Dermatology, chaired by Mark A. Everett, MD (1964); and Laboratory Medicine, chaired by Ben I. Heller, MD (1964).

However, it was the early arrivals from 1952 to 1961 that changed the face of the medical school. These were the pioneers, especially Wolf, West, Schilling, Riley, and Merrill. They were innovators and exerted profound influence on the growth and development of the college and the Health Sciences Center. Their enormous legacy will not be forgotten.

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SPECIAL

An Analysis of Factors Associated with Seat Belt Use: Prevention Opportunities for the Medical Community

Daryl R. Baker, MPH; S. Ross Clarke, PhD; Edward N. Brandt Jr., MD, PhD

Motor vehicle collisions are a significant cause of morbidity and mortality in the Oklahoma population. The cost associated with this morbidity and mortality is exacerbated by the failure of individuals to use seat belts. Numerous organizations believe that seat belt compliance can be improved through physician counseling. This would allow medical resources to be redirected towards other health problems.

Analysis was performed using the Oklahoma Department of Public Safety (ODPS) crash file and the hospital in-patient data discharge file from the Oklahoma State Department of Health (OSDH). These provide a profile of Oklahoma drivers who do not use seat belts. This analysis allows physicians to pinpoint and advise those individuals most likely to not utilize seat belts about the benefits of seat belt use.

The results of the analysis show that non-seat belt-users tend to be young and male. Significant predictors of seat belt use are age, gender, alcohol use, time of day (day versus night), driver location (urban versus rural), vehicle type (pick up versus passenger car), and decreased hospital charges.

These results show that increased seat belt use can lead to significant decreases in fatalities related to motor vehicle crashes and a decline in associated hospital charges for those who survive. Physicians should encourage seat belt use by their patients and inform them of the risks associated with failure to use seat belts.

Introduction

The aim of traffic safety programs has been to increase the safety of automobiles and thus reduce the severity of injuries associated with crashes. Safety belt use is a preventive measure that drivers and passengers can utilize to reduce injury severity in crashes. Numerous studies have proven the link between seat belt use, reduced injury severity, reduced fatalities, and reduced hospital costs.[1,2,3] Due partially to education efforts and partially to the adoption of seat belt laws (primary and secondary) by states, seat belt use has shown a significant increase over time, from 15% in 1983 to 67% in 1994.[4] This increasing compliance suggests that the objective at present should be to redirect prevention efforts from the population at large to high-risk populations for non-use of seat belts. The scope of this problem, coupled with the social, fiscal, and resource implications, suggests that a greater role can be taken by physicians who can advise patients to use seat belts, especially those who do not currently use them.

The purpose of this analysis is to determine the patterns of seat belt use by Oklahoma drivers and the predictive value in determining hospital charges and length of stay. The data used in this analysis was drawn from the 1995 Oklahoma Department of Public Safety collision files, which contain some 184,000 records utilizing information from police crash reports, and the Oklahoma State Department of Health in-patient hospital discharge files, which contain some 360,000 records. Along with specific examination of the collision records, this file was linked with the in-patient discharge file to create a chain of events from the crash to the final release of individuals allowing for a more comprehensive analysis of these data. (The Crash Outcomes Data Evaluation System [CODES] is a project of the Oklahoma Traffic Records Council, the Oklahoma Highway

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Safety Office, the University of Oklahoma Center for Health Policy at the Health Sciences Center, and the National Highway Traffic Safety Administration.)

The utility of this data set is that it originates from police reports and in-patient discharge files, which provide the best source of motor vehicle collision (MVC) data and hospitalized patient data. In particular, police reports on age, sex, and crash type have been found to be generally reliable.[5]

It is important to note that not all of the databases come from the same source. Although these various data are collected by different agencies and coded into different locations, each provides valuable information. Additionally, it is more prudent to use existing databases before spending the extra money, time, and effort to collect what would essentially be information that is already on record.[6] As a result, data linkage, a common practice of combining data from different sources, is utilized to take full advantage of the disparate data sets. Data linkage can provide a more thorough and complete picture of MVCs in a state because one database may contain police crash reports, while others may be comprised of hospitalization data and ambulance run reports.[7]

Literature Review

In the United States, motor vehicle crashes are one of the top ten leading causes of death and the leading cause of death for persons 1 to 34 years of age.[4,8,9] Estimates of the human toll of crashes are 44,000 annual deaths; injuries totaling approximately 4,000,000; average yearly hospitalizations of 500,000; and potential years of life lost prior to age 65 of 1,000,000.[2,8,9] The estimated annual economic loss to American society is approximately $150 billion.[9]

The tragedy is that a significant percentage of these fatalities, as well as the severity of injuries incurred in crashes, can be decreased through the use of seatbelts. Injury rates have been shown to be decreased significantly by the use of safety belts. It is estimated that seat belt use can reduce the prevalence of fatal injuries by 45% and can reduce the prevalence of moderate injuries by 50%.[4,8,9] The National Highway Traffic Safety Administration (NHTSA) estimates that seat belt use saved 9,797 lives in 1995 and in excess of 75,000 lives from 1982 through 1995.[10] In Oklahoma nearly 70% of vehicle fatalities in 1995 were not using restraints at the time of impact.[11] However, despite the known benefits of seat belt use, a large proportion of individuals continue to drive without safety belts.

By 1995, mandatory use laws had been enacted in 49 states, the District of Columbia, and Puerto Rico.[11] Nelson et al[4] have shown that increased seat belt use is most rapid in the initial years following passage of mandatory use laws, regardless of type (primary or secondary). A study of states passing secondary laws between 1987 and 1990 show an average increase in self-reported seat belt use of 7.3% per year, declining to an annual increase of 1.3% from 1990 to 1993. In addition, in states with primary enforcement laws, self-reported seat belt use prevalence is higher than in states with secondary enforcement laws.

Previous studies show that seat belt use is greater among women and is associated with increasing age.[1,2,4,12] Failure to use seat belts is also associated with a number of high-risk behaviors such as obesity, drinking, and inactivity.[2,8,12,13] As a group, non-users tend to have a greater risk of head injury, longer hospital stays, greater hospital charges, and higher fatality rates.[2] When non-users were questioned about their reasons for not using a seat belt, the most common responses included physical discomfort, trips of short duration, and forgetfulness.[8]

Given the perceived benefits of seat belt use, the United States Preventive Services Task Force recommended in 1994 that physicians include routine counseling on the benefits of seat belt use when seeing patients. This stance supported the position taken by organizations such as the American Medical Association (AMA), the American College of Physicians, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists in the 1980s.[8,14] However, a survey by the American College of Physicians found that only 11% of physicians surveyed offered routine counseling on seat belt use.[8]

This information illustrates a lost injury prevention opportunity. In a review of patient/provider communication literature, Kreps and O'Hair[15] point out that numerous studies have offered convincing evidence of the positive contribution of communication between physicians (as well as other health care providers) and patients in reducing risk behavior, such as the lack of restraint use. Fisher[16] indicated that the role of a physician in the relationship places him or her in a stronger position of authority to provide positive injury prevention messages than other health care professionals. It is well documented that health messages to parents of the young tend to have higher compliance and receive longer-term attention than those messages directed at other adults,

Table 1. Motor Vehicle Collision Frequencies, by Category

Variable	N	Frequency (%)
Gender	146,906	Mole – 83,744 (57) Female – 63,162 (43)
Seat Belt Use	133,885	Yes – 107,483 (80.3) No – 26,402 (19.7)
Fatalities	146,906	Yes – 553 (.4) No – 146,353 (99.6)
Alcohol Involved	138,205	Yes – 4,066 (2.9) No – 134,139 (97.1)
Vehicle Type	130,275	Passenger – 97,583 (74.9) Pick up – 32,692 (25.1)
Time of Day	136,899	Day – 106,175 (77.6) Night – 30,724 (22.4)

Table 2. Linked and Unlinked Data Files Frequencies

Measure	Percentage (N)
Male	57 (83,744)
Fatalities	0.4 (553)
Night	22.4 (30,724)
Alcohol Involved	2.8 (4,066)
Urban Location	69.5 (4,071)
Seatbelt Use	80.3 (107,483)

hence providing an opportunity for risk reduction by restraint use at younger ages.

Methodology

The statistical model involves an exploratory data analysis (EDA) and a multivariate logistic regression analysis. The study was limited to drivers of passenger vehicles and pick up trucks. Seat belt use was established as the dichotomous outcome variable (dependent variable) and was defined as the use of either a lap belt or a combination of shoulder belt and lap belt. Use of a shoulder belt alone is constituted as unbelted for purposes of this study since it does not offer significant protection and as a result individuals so coded, along with individuals for whom seat belt use was unknown, were eliminated from the analysis.

Seat belt use for the exploratory data analysis was evaluated by gender, age, fatalities, alcohol use, vehicle type (constrained to passenger cars and pickup trucks), time of day (daylight versus night), length of hospital stay (LOS), and average hospital charges. The LOS and hospital charge data were analyzed using the probabilistically linked files, therefore yielding a much smaller sample size (4,245 versus 146,906) than for the unlinked crash data file.

For purposes of the logistic regression, seat belt use was established as the outcome (dependent) variable, and age, gender, fatalities, alcohol use, vehicle type, time of day, location (urban versus rural), and LOS as the independent variables. Records with missing data were eliminated from the analysis.

Results

There were 146,906 drivers involved in automobile crashes in 1995. However, because of missing data, the frequencies reported here are based on varying sample sizes for each category (see Table 1). Of the 146,906 drivers involved in reported automobile collisions, 133,885 had data available on seat belt use. Of that number, 107,483 (80.3%) were wearing seat belts. The mean age for this population was 36.5 years and was mostly male (57% versus 43%). There were 553 driver deaths from automobile collisions in 1995, constituting .4% of the sample. Of all crashes, 22.4% occurred during nighttime hours, and alcohol was involved in 2.8% of crashes. Unbelted drivers were slightly younger than belted drivers on average (33.6 years vs. 37.3 years).

As part of the overall sample, males tend to be unbelted with greater frequency than females. They accounted for 64.8% of unbelted drivers. When examined in terms of gender subsets, there were 76,266 male drivers in collisions and 17,121 (22.4%) were not wearing seat belts. By contrast, there were 48,338 females wearing seat belts versus 9,281 (16.1%) of female drivers not wearing seat belts. There were 553 drivers killed in Oklahoma crashes in 1995 and unbelted individuals accounted for 82.4% of all fatalities.

Alcohol was involved in 2.8% (4,066) of all automobile crashes in 1995 (Table 2). When alcohol involvement is compared on the basis of seat belt use, drivers not wearing a seat belt accounted for 8.9% of collisions involving unbelted drivers versus belted drivers where alcohol was involved in 1.3% of collisions. Passenger vehicles accounted for 74.9% (97,583) of all such vehicles involved in crashes in 1995. Pick up truck drivers account for an increased percentage of unbelted drivers (36.6%). Crashes were also evaluated on the basis of day versus night driving with 22.4% (30,724) of all crashes occurring at night. For individuals wearing a seat belt, 20.2% (20,674) of crashes occurred at night as compared to individuals not wearing a seat belt, where 26.2% (7,346) crashes occurred at night.

Linking the DPS crash file to the Hospital Discharge Data Set for purposes of hospital length of stay and charge data yields a sample size of 4,245 individuals. The average hospital charge is $9,307.70 with an average length of stay of 4.66 days. When compared on the basis of seat belt use, an individual not using their seat belt has an average charge of $12,059.51 with an average hospital stay of 5.69 days versus an individual wearing a seat belt with average charges of $8,039.45 and an average stay of 4.23 days. A comparison of the means for each category indicates that the differences are significant at the .05 level.

The logistic regression for the linked data files shows that age, gender, fatalities, alcohol use, time of day, driver location, vehicle type, and total hospital charges are significant predictors of seat belt use. An examination of the odds ratios indicate that the greatest association between non-use of seat belts exist with the predictor variables fatalities, alcohol use, and urban driver location. The odds of a person being killed in automobile crash not wearing a seat belt are 5.47 times the odds of a person not being killed in an automobile crash (see Table 3). Alcohol use is another strong indicator of failure to use a seat belt, with an odds ratio of 5.35. Additionally, the odds of a driver from urban areas not wearing a seat belt are 2.10 times the odds of a person from a rural area not wearing a seat belt.

In summary, the analysis of the 1995 collision file and linked collision/in-patient discharge files is shown in Table 4.

Table 3. Odds Ratios

Independent Variable	Odds Ratio	Confidence Interval
Gender - Male	1.46	1.24 – 1.72
Fatality	5.47	1.81 – 16.53
Alcahal	5.35	3.78 – 7.57
Vehicle - Passenger	.65	.55 – .78
Location - Urban	2.10	1.80 – 2.46
Night	0.76	.64 – .92

Table 4. Percentages and Means for Seat Belt Use versus Non Seat Belt Use

Measure	Belted	Unbelted
Gender - Male	55%	64.8%
Fatality	.1%	1.3%
Alcohol Use	1.3%	8.9%
Pick up Truck	22.6%	36.6%
Night	20.2%	29.9%
Mean Age	37.3 yrs	33.6 yrs
Hospital Charges	$8,039	$12,059
Average Length of Stay	4.23 days	5.69 days

Policy Implications

In 1995, 80.3% of drivers in Oklahoma involved in automobile crashes reportedly wore seat belts; this conflicts with observational studies of an overall use of only 60.2%, suggesting that seat belt use is over-reported in police reports. This over reporting phenomenon is consistent with existing research results. Oklahoma has recently passed a primary seat belt law so it may be expected that the percentage of individuals wearing seat belts will increase. This hypothesis is supported by a study of seat belt usage trends indicating that the most rapid increase in seat belt use occurs in the three-year period immediately following passage of a seat belt law.[4]

The focus of prevention and education programs should shift from the general population to specific high-risk populations. For Oklahoma, programs should be geared towards young males in rural areas. Issues to highlight include the increased risk of fatality associated with not wearing a seat belt and the increased health care costs associated with more severe injuries. An increase in seat belt use has tremendous potential to save lives and decrease hospital costs, thereby allowing precious medical resources to be diverted to other problems. The National Highway Transportation Safety Administration (NHTSA) estimates that more than 75,000 lives were saved from 1982 to 1995 by the use of restraint systems.[10]

The limitations of this study must be addressed. First, any study conducted in the field may include confounding factors that cannot be avoided as rigorously as they are in a more controlled environment. Specifically, the data for this study came from a census of Oklahoma law enforcement agencies and various state hospital records for the period.

The success of environmental policy change programs have taken place in numerous contexts, generally with the support of the medical community. For example, the decrease in the minimum legal drinking age (MLDA) in the early 1970s led to an increase in the number of young drivers involved in fatal crashes.[17] In response, states—with the encouragement of the medical community—began in the late 1970s to increase the MLDA; in 1988 when all states had enacted 21-year MLDA, deaths in this group decreased.[18] The medical communi-

ty's injury prevention research agendas must continue to not only evaluate public policy, but also build and reinforce it.

Other injury-prevention issues can benefit from these findings. Evidence clearly indicates that seat belts save lives; unfortunately, common fallacies exist in much of the general population. Recognizing and dispelling these myths provide physicians with an immediate opportunity to positively impact the issue of seat belt use. Opportunities exist with the continued passage of mandatory seat belt legislation to study seat belt use and the effect of campaigns similar to the Oklahoma Zero Tolerance campaign. Future research must address the possibility that campaigns (such as the present one) could lead to a less significant increase in morbidity and mortality associated with failure to use seat belts.

Physicians should encourage seat belt use by first determining whether the patient regularly uses them. If not, patients should be informed of the increased risk of serious injury or death in a traffic crash.

Acknowledgements

This article was made possible by Crash Outcome Data Evaluation Set (CODES) funding administered through the National Highway Transportation Safety Administration and the Oklahoma Highway Safety Office (Joe McDonald, Director). The authors gratefully acknowledge the assistance of the aforementioned organizations as well as the assistance provided by the Oklahoma Department of Public Safety (Bob Ricks, Commissioner) and the Oklahoma State Department of Health (Sue Mallonee, Director of the Center for Health Statistics).

The Authors

Daryl R. Baker, MPH, is a research assistant at the Center for Health Policy and a doctoral candidate in the Department of Health Administration & Policy at the University of Oklahoma Health Sciences Center in Oklahoma City. S. Ross Clarke, PhD, is an assistant professor in the Department of Health Administration & Policy and the associate director of the Center for Health Policy at the University of Oklahoma Health Sciences Center in Oklahoma City. Edward N. Brandt, Jr., MD, PhD, is a regents professor and chair of the Department of Health Administration & Policy and director of the Center for Health Policy at the University of Oklahoma Health Sciences Center in Oklahoma City.

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Frequently Asked Questions and Their Answers Regarding State Question 692

Q. What is State Question 692?

A. SQ 692 is a proposed amendment to the Oklahoma Constitution that, if approved by a majority of Oklahoma voters on November 7, will create a constitutional trust fund into which tobacco settlement payments will be deposited.

Q. Why is it important to create a constitutional trust fund?

A. A trust fund created in the Oklahoma Constitution will protect nearly $1.9 billion of tobacco settlement payments designated for Oklahoma over the next 25 years and ensure the earnings from the trust fund will be used for the following purposes *only*:

- Research on cancer and other tobacco-related diseases;
- Cost-effective tobacco prevention and cessation programs;
- Health care programs with a particular emphasis on children;
- Education-related programs; and
- Programs designed to enhance the well being of senior citizens.

Q. Can future Oklahoma legislatures change this?

A. No! A constitutional amendment approved by a vote of the people can only be changed by another vote of the people and not by the legislature.

Q. Why is Oklahoma receiving this money?

A. Oklahoma's Attorney General joined with those of several other states in suing major tobacco companies. The payments to Oklahoma and other states are the result of a settlement agreement. In fact, Oklahoma will receive an additional $267 million because we filed an individual lawsuit early.

Q. Who decides how these funds will be invested?

A. SQ 692 establishes a five-member Board of Investors chaired by the State Treasurer and charged with prudently investing trust fund monies in a manner similar to that of the state's retirement systems.

Q. Even though SQ 692 specifies how the earnings are to be spent, who makes those decisions?

A. SQ 692 creates a seven-member Board of Directors that will distribute the earnings from the trust fund *only* for the purposes previously stated. Board members must have expertise in public or private health care or programs related to or for the benefit of children or senior adults.

Q. Who appoints the Board of Directors?

A. Appointments, one each, are made by the Governor, President Pro Tempore of the Senate, Speaker of the House, Attorney General, State Treasurer, State Auditor and Inspector, and the State Superintendent of Public Instruction.

Q. Do all tobacco settlement payments go into the trust fund?

A. A minimum of 50% of the payments goes to the fund in 2002. The percentage increases by 5% each year until it reaches 75% in 2007 and remains at 75% thereafter.



Patient Handout #10

Q. What will happen to the payments that are not deposited into the trust fund?
A. Even these payments will be set aside and deposited into a special account. These funds will not be certified as revenue so the legislature will have to vote to remove funds from the special account.

Q. Do programs for tobacco prevention and cessation really work?
A. Yes! Studies of programs in California, Massachusetts, and Florida have shown conclusively that smoking rates in those states fell 15% to 54% within 2 to 5 years for various populations following the introduction of comprehensive community-based programs. Medically proven, cost-effective programs do exist.

Q. Why fund tobacco cessation and prevention programs?
A. According to the *Oklahoma Youth Tobacco Survey Report,* 49% of current smokers in middle school and 48% of those in high school want to stop smoking. And 75% of adults say they want to quit, according to the State Office of Tobacco Use Prevention.

Q. What does tobacco use cost Oklahomans?
A. Tobacco use costs Oklahomans over $1 billion in medical expenses and lost productivity every year, or an average of about $300 per person. Of that amount, approximately $80 million per year comes from Medicaid funds.

Q. Why is it so important that SQ 692 be approved?
A. If approved, SQ 692 will provide funding for critically needed programs to improve the health and well being of all Oklahomans. According to the *2000 State of the State's Health Report,* Oklahoma has the:

- 7th highest rate in the nation for deaths from heart disease;
- 12th highest rate of deaths from stroke; and
- 7th highest rate of deaths from emphysema.

Smoking plays a significant role in all of these conditions. In the final analysis, it's just a fact that people who smoke are less healthy than those who don't. This problem is compounded in Oklahoma by the fact that we have a large number of smokers, and, per capita, Oklahomans smoke more than persons in other states. In addition, we also have a large number of people (532,000 individuals or 22.5% of the population between the ages of 18 and 64) who have no health insurance. When people lack access to routine health care, they are often forced to seek treatment in emergency rooms for non-emergency conditions. These factors combine to drive up the cost of health care for all of us.

What's even worse, perhaps, is the fact that, without intervention, these figures are unlikely to improve for the next generation when one considers that 42% of Oklahoma's high school students are currently using tobacco in some form and are at risk for lifelong nicotine addiction and the health problems that it produces.



Q. What happens to the tobacco settlement payments if SQ 692 fails in November?
A. The settlement payments will most likely become part of the state's general revenue fund and may be used to help fund **any** state program.

Consider Your Vote on SQ 692!

Paid for by the Oklahoma State Medical Association, 601 Northwest Grand Boulevard, Oklahoma City, OK 73118, Robert J. Weedn, MD, President

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Patient Handout #10

In Memoriam: Brenda F. Hays



Brenda F. Hays
OSMA Director of Communications

Brenda F. Hays, APR, OSMA Director of Communications, died September 29, 2000, after a brief illness.

Brenda, an accomplished professional in the field of public relations, joined the OSMA in February 1999 to increase the OSMA's visibility in the community. Through her involvement in and direction of projects such as the "Take Care" campaign, the Oklahoma Health News Network, and the release of the *State of the State's Health Report,* Brenda established relationships with both print and broadcast media from across the state on behalf of the organization. In addition, her award-winning communication skills were integral to the development and production of the 1999 *Legislative Report*, the redesign of the OSMA Web site, and the Rapid Response Team.

An accredited public relations practitioner, Brenda graduated magna cum laude from the University of Central Oklahoma with a Bachelor of Arts degree in public relations and marketing in 1978. She has held senior writer, advertising manager, marketing and public relations director positions throughout her career and also maintained an independent public relations and communications practice for a number of years before joining OSMA. Her honors and awards include: an Addy Silver Award and Addy Merit Award from the Oklahoma City Advertising Club; an Upper Case Award and two Upper Case Awards of Merit from the Oklahoma City Chapter of the Public Relations Society of America; the Silver Cassette Award for External Communications from the International Television Association; the First Place Video Award from the National Association of Temporary Services; and an Award of Merit from the International Association of Business Communicators. Most recently Brenda was awarded the 2000 APEX Award of Excellence for the 1999 *Legislative Report* by Communications Concepts.

As Director of Communications, Brenda staffed both the Council on Public Relations and the Council of Professional Communications, and was a member of the Physicians' Campaign for a Healthier Oklahoma Task Force. Her skill, experience, and expertise in the field of communications enabled Brenda to redefine and establish the Director of Communications position—a position that had been vacant for some time—using the goals adopted by the Board of Trustees and House of Delegates based on information provided by the Council on Long-Range Planning and Development.

Brenda is survived by her husband, Dr. John B. Hays, a veterinarian; her daughter, Jennifer Grigsby and husband Steve; her son Russell Boyd Reid; her stepdaughters, Sarah Washam and husband Danny, and Tiffany Massey and husband Ryan; her niece, Lisa Penner and husband Michael. She is also survived by her grandchildren and a grand-niece and -nephew: Reid Thomas Grigsby, Kristina Daniel and Jonathon Drew Washam, and Nicholas and Samantha Penner.

Brenda's professionalism and expertise were an asset to the OSMA, and her personal character—an avid golfer and unabashed animal lover with a sharp, quick wit and unparalleled command of the English language—have touched many in the Association staff and membership, and we remember her with both sadness and pride.

Brumback Establishes Endowed Professor in Honor of Revolutionary War Ancestor

Roger Brumback, MD, David Ross Boyd Professor and interim chair of the Department of Pathology at the University of Oklahoma Health Sciences Center in Oklahoma City, has endowed a professorship in honor of an ancestor who fought in the Revolutionary War and his descendants.

The Brumback Family Distinguished Professorship in Pathology was established to honor Peter Brumback and will support a position in anatomic pathology. Richard Leech, MD, OU professor of pathology, director of anatomic pathology, and former department chair, is the first to hold the Brumback professorship.



Dr. Roger Brumback (left), interim chair of the Department of Pathology at the University of Oklahoma Health Sciences Center in Oklahoma City, and Maryanne Maletz (right), Oklahoma State Regents vice chancellor for budget and finance, congratulate Dr. Richard Leech (center) on being named the first holder of the Brumback Family Distinguished Professorship in Pathology.

Influenza Vaccine Supply Delays, Shortages Expected

The Centers for Disease Control and Prevention (CDC) is expecting delays in this year's influenza vaccine shipments, as well as a possible shortage of the vaccine for the 2000-2001 flu season. Manufacturing issues, including a lower-than-expected yield of the vaccine's component, have contributed to this expected delay and possible shortage.

The CDC is encouraging health care providers to develop contingency plans to ensure their high-risk patients receive the flu vaccine as well as those in close contact with persons at high risk for complications from influenza. In addition, the CDC is emphasizing the importance of reducing waste of the influenza vaccine. Purchasers are being asked to not place duplicate orders with multiple companies to minimize the amount of the vaccine that is returned to the manufacturer and discarded. For more information on influenza and the vaccine, visit the CDC's Web site at http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm, or call the Immunization Division of the Oklahoma State Department of Health at 405/271-4073.

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CDC Influenza Vaccine Recommendations for 2000-2001 Influenza Season Only

- Organized influenza vaccination campaigns should be delayed until November to minimize cancellations of vaccine campaigns and wastage of vaccine doses resulting from such cancellations.

- Influenza vaccination of persons at high risk for complications from influenza and their close contacts should proceed routinely during regular health-care visits. This is particularly important for young children at high risk who are receiving influenza vaccination for the first time and who require two doses of vaccine.

- Providers should develop specific contingency plans for an influenza vaccine shortage to maximize vaccination of high-risk persons and health care workers.

- Influenza vaccine should be offered to unvaccinated persons throughout the influenza season.

- Minimizing influenza vaccine waste is particularly important. Purchasers should not place duplicate orders with multiple companies; this should minimize the amount of vaccine that is returned to the manufacturer and discarded.

- In 2000, the Advisory Committee on Immunization Practices (ACIP) broadened its influenza vaccine recommendations to include all persons ages 50 to 64. There is no change in this recommendation at this time; however, if a vaccine shortage occurs, it would be appropriate to vaccinate persons with high-risk conditions in this age group rather than the entire age group.

- Vaccine providers should keep in mind that pneumococcal vaccine is recommended for many of the same people for whom influenza vaccine is indicated. Use of pneumococcal vaccine could reduce some of the bacterial complications of influenza infection.

- There are no new recommendations for the use of influenza antiviral drugs. Even if an influenza vaccine shortage develops, CDC does not support their routine and widespread use to prevent influenza because this is an untested and expensive strategy that could result in large numbers of persons experiencing adverse effects.

- The CDC will establish a Web site to provide information on where to obtain additional influenza vaccine supplies. Local or state health departments may have information on vaccine availability in local areas.

Intimate Partner Violence

Sheryll Brown, MPH; Cassandra Smith-Edwards, MA
Injury Prevention Service, Oklahoma State Department of Health

The Problem:
Intimate Partner Violence

Domestic violence technically refers to all crimes between family members. The term is often used interchangeably to refer to spousal abuse and battering. More recently, intimate partner violence (IPV) is the term used to refer to that specific subset of domestic violence that occurs between current or former marital and non-marital partners, including dating and courtship relationships and same-sex partners. According to the American Medical Association's *Diagnostic and Treatment Guidelines on Domestic Violence*, this type of violence results from the abuse of power of a physically more powerful person over a physically less powerful person.

How Bad is the Problem?
Who is Affected?

Intimate partner violence occurs among all ages, races, genders, and socioeconomic groups. However, the US Bureau of Justice reports that women are more than seven times more likely to be victimized by an intimate partner than men. About 16% to 30% of female trauma patients in emergency departments are there for injuries directly or indirectly related to abuse. The Centers for Disease Control and Prevention (CDC) reports that 1.3 million women are assaulted and 200,000 women are raped by intimate partners annually. In Oklahoma, surveys indicate that 4% to 7% of women are physically assaulted by their partners annually. Additionally, 20% of all homicides in the Oklahoma City Metropolitan Statistical Area (OKCMSA) during 1997 occurred as a result of IPV; 79% of those victims were female. IPV ranks as one of the nation's most expensive health problems and costs an estimated $5 billion to $10 billion per year in health care, lost productivity, and criminal justice interventions.

Studies have identified several factors that increase a woman's risk of IPV including younger age, pregnancy, alcohol and drug abuse, poverty, and unemployment of the spouse/partner. More than half of women who are abused live in households with children 11 years of age or younger. Nationally it is estimated that more than 10 million children witness IPV within their families each year. Annually in Oklahoma approximately 18,000 women and children seek shelter or crisis intervention for domestic violence at Department of Mental Health and Substance Abuse Services facilities.

What is Being Done
to Address the Problem?

In 1992, the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) issued recommendations calling for hospital emergency departments (ED) to establish written policies and procedures for assessing, treating, and referring women who are abused. The American Medical Association (AMA) has established policies calling for physicians to routinely screen female patients for violence and provide referral to specific resources. The AMA supports ongoing efforts to track violence-related injuries and encourages the development of public health surveillance systems.

Since 1995, the CDC has funded seven states to develop IPV programs. The purpose of these programs is to conduct surveillance, improve data collection systems, determine the magnitude and epidemiology of IPV-related deaths and injuries, and identify risk factors that can be targeted for prevention. In October 1999, the Injury Prevention Service (IPS) of the Oklahoma State Department of Health (OSDH) received a grant from the CDC to conduct IPV surveillance. During the first two years of funding, IPV surveillance will be implemented in the OKCMSA and then implemented statewide by the third year.

In October of 1999, IPV injuries were mandated reportable conditions by Oklahoma's Commissioner of Health under Title 63, O.S. 1-106. This mandate authorizes the OSDH to collect data for persons killed or injured as a result of IPV. Hospitals in the OKCMSA are required to report IPV injuries treated in EDs. The IPS will abstract data from hospital inpatient records. Additionally, the Office of the Chief Medical Examiner will enhance investigations of IPV fatalities by conducting complete toxicology testing and interviewing family members. The data will be compiled in an electronic database and a newsletter will be distributed to hospitals as the data is processed.

One primary premise of the Oklahoma IPV surveillance program is that health care providers have a unique opportunity to intervene in IPV. Studies suggest that women are more likely to disclose IPV to their doctors than to other professionals, including police officers, social workers, and ministers. Of women who report IPV, 10% to 28% report using medical care services as a result of IPV. Additionally, in a study of IPV homicides and attempted homicides, 42% of victims had used health care services and 26% of victims had used ED services prior to the event.

As part of the Oklahoma IPV surveillance program, all 19 OKCMSA hospital EDs received in-service training on screening, assessing, and referring IPV patients treated in the ED. Beginning July 1, 2000, ED personnel were asked to incorporate a two-question IPV screening tool into their patient evaluation. The screening tool allows ED staff to identify abused patients, assess for safety, and to determine whether or not the injuries were caused by IPV. A resource packet

including information, educational materials, and referral numbers was provided to each emergency department. IPV injuries identified are reported to the OSDH.

What Do We Need to Do?

Traditionally, IPV has been addressed through social agencies and the criminal justice system. However, for the women who are physically abused by their partners each year, the health care system is a primary resource. According to a report released in November 1998 by the National Institute of Justice and the Centers for Disease Control and Prevention, women made 693,933 visits to health care system per year for domestic violence injuries.

The health care provider has a critical role in helping victims of family violence. By incorporating a screening protocol into patient evaluation, the patient is given an opportunity to disclose the abuse. Screening is important for several reasons, including: 1) increasing detection of IPV; 2) identifying injuries caused by IPV; 3) improving medical documentation of IPV; and 4) identifying patients who may be in danger.

Ideally, every woman should be screened, at every visit, and for every diagnosis. Strict guidelines must be followed to conduct IPV screening. The screening should be administered in an interview format and only be conducted in privacy—never in the presence of family members or friends. The screening should be delivered in a matter-of-fact manner so that patients don't feel singled out. Questions might be prefaced with a statement such as, "*Because violence is such a problem in our society, I've started asking all my patients about it routinely.*" Practically, it is not always possible to screen every woman, every visit, and for every diagnosis. The barriers include time, asking questions that may offend some patients, and not being prepared to deal with a patient who is being abused. To assist ED personnel in this task, the Oklahoma IPV surveillance program is committed to providing ongoing training, information, and resource materials.

In August 2000, Oklahoma and 34 other states received a grade of "D" by the Family Violence Prevention Fund (FVPF) for lacking laws aimed at improving the health care response to domestic violence. The FVPF rated states on their laws in five critical areas: training, screening, protocols, reporting, and insurance. Only four states had enacted screening laws and nine states had enacted laws requiring health care systems to have written policies on domestic violence. Oklahoma was one of 11 states that had enacted laws addressing training; however, Oklahoma's laws require medical providers to be offered only non-mandatory training.

The OSDH IPV program can help reduce the prevalence of IPV and improve the state's health care response to domestic violence by screening patients, conducting surveillance to determine the magnitude of the problem and who is at risk, assessing the risk factors and needed services, and developing prevention strategies. For more information about the program, contact Sheryll Brown at 405/271-3430 or 800/522-0204.

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1999

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Theodore Turnbull, MD October 19
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Malcolm Horne, MD November 3
William Clark Cheek, MD November 11
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2000

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Obituaries

Joseph D. Weedn, MD
1919-2000

Joseph D. Weedn, MD, died May 14, 2000. Born October 29, 1919, in Cyril, Dr. Weedn attended the University of Oklahoma and received his medical degree in 1954. From 1942 to 1945, he served in the United States Air Force. In 1984, Dr. Weedn was named a life member of the Oklahoma State Medical Association.

Camp S. Huntington, MD
1912-2000

Camp S. Huntington, MD, died July 29, 2000. Dr. Huntington was born August 21, 1912, in Washington, DC. In 1939 he received his medical degree from the George Washington University School of Medicine. From 1941 to 1946, Dr. Huntington served in the Army Medical Corps; during that time, he received the Asiatic Pacific ribbon with one star, the Philippine Liberation ribbon, and the Army Commendation ribbon. Dr. Huntington was a past president of the Washington/Nowata County Medical Society and a life member of the Oklahoma State Medical Association since 1982.

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Course offerings from OSMA-accredited institutions

Deaconess Hospital: Yvonne Curtright 405/604-4979

Oct.	05	Cancer Conference	12:15 pm	1 hour
Oct.	12	Cancer Conference	12:15 pm	1 hour
Oct.	16	Cancer Conference	6:30 pm	1 hour
Oct.	19	Cancer Conference	12:15 pm	1 hour
Oct.	26	Cancer Conference	12:15 pm	1 hour

Duncan Regional Hospital: Amy Wade 580/251-8648

Oct.	31	To Be Announced	12 noon	1 hour

Hillcrest Medical Center: Linda Gondles 918/579-5235

Oct.	10	"After Rehabilitation...What?"	7:30 am - 3:00 pm	

Integris Southwest Medical Center: Jonathan Stotler 405/636-7087

Oct.	04	Coronary Heart Disease: A New Agenda	12:15 pm	1 hour
Oct.	11	Management of Community Acquired Pneumonia	12:15 pm	1 hour
Oct.	18	"Tamoxifen in Women at Increased Risk of Breast Cancer"	12:15 pm	1 hour
Oct.	25	Wound Therapy and Hyperbaric Medicine	12:15 pm	1 hour

Mercy Health Center: Debbie Stanilla 405/752-3806

Oct.	03	"Update on Adjunct Systemic Treatment for Breast Cancer" Multidisciplinary Breast Conference	7:00 am	1 hour
Oct.	05	"The Use of Genetic Information in Medical Practice Litigation"	12:15 pm	1 hour
Oct.	12	"History of Medicine in the 19th Century"	12:15 pm	1 hour
Oct.	18	"Stage II Non-Small Cell Lung Cancer"	7:00 am	1 hour
Oct.	18	"Ethical Issues in Health Policy" (Ethics for Lunch)	12 noon	1 hour
Oct.	19	Cardiovascular Testing	12:15 pm	1 hour

St. Anthony Hospital: Sandy Coury 405/272-6358

Oct.	06	"Chronic Total Occlusion"	8:00 am	1 hour
Oct.	09	MGR: "Update In Pulmonary Medicine"	8:00 am	1 hour
Oct.	13	"Ischemic Preconditioning"	8:00 am	1 hour
Oct.	14	"End of Life Care: A Holistic Approach"	8:00 am - 3:00 pm	
Oct.	16	Heart Conference: TBA	8:00 am	1 hour
Oct.	18	OB/GYN Conference: TBA	12 noon	1 hour
Oct.	19	"Spirituality: Its Role in Assessment/ Treatment Planning"	12 noon	1 hour
Oct.	20	"Abrupt Vessel Closure"	8:00 am	1 hour
Oct.	23	Medical Grand Rounds (MGR): TBA	8:00 am	1 hour

St. John Medical Center: Gail Hilst 918/744-2875

Oct.	05	Critical Care Conference: Acute Abdomen	12 noon	1 hour
Oct	10	Critical Care Conference: Adrenal Disorders	12 noon	1 hour
Oct.	12	Critical Care Conference: Anaphylaxis	12 noon	1 hour
Oct.	17	Critical Care Conference: Acute Spinal Cord Injury	12 noon	1 hour
Oct.	19	Critical Care Conference: Acid-Base 1	12 noon	1 hour
Oct.	24	Critical Care Conference: Management of Upper GI Bleed	12 noon	1 hour
Oct.	26	Critical Care Conference: Physiologic Basis of Blood Transfusion	12 noon	1 hour

Valley View Regional Hospital: Belinda Runnells 580/421-1467

Oct.	06	"Current Treatment of Antibiotic-Resistant Organisms"	12 noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator at 405/843-9571 or 800/522-9452.

Improving Health by Changing Lifestyles

Helping save schools from violence is an awesome task for the AMA Alliance, OSMA Alliance, and county Alliances to tackle. But that is just what we are doing this October. The AMA Alliance, led by Oklahoman Susan Paddack, has made SAVE (Stop America's Violence Everywhere) puzzles available to county Alliances to take to their community elementary schools. Made possible by a grant from the AMA Foundation, the SAVE puzzle project helps to open a dialogue about violence with 8- to 11-year-olds and lets them know that their school is a safe place to talk about violence, including bullying and other types of peer conflict. The US Department of Education states that one in four children who are bullies will have a criminal record by the time they are 30 years old. More than 2,000 puzzles will distributed throughout Oklahoma, and 50,000 puzzles nationally.



Julie Weedn, OSMAA Health Promotions Chair

October is Breast Cancer Awareness Month. Some of our county Alliances are hosting projects to remind women to have an annual mammogram. Many cancers that cannot be felt during a monthly breast self-exam can be found on a mammogram. Statistics show that one in eight women develop breast cancer. This fact should be significant motivation for an annual mammogram as early detection will result in a better cure rate.

For the past three years, the Oklahoma State Department of Health's *State of the State's Health Report* has revealed data that unhealthy lifestyles are mainly responsible for the increased death and disability rates in Oklahoma as compared to the rest of the nation in the areas of heart disease, cancer, injury, stroke, and chronic pulmonary disease. The OSMA Alliance and the county Alliances are creating and implementing programs to address our state's current unhealthy status. Our projects, targeted at local communities, address smoking, violence, and healthy lifestyle habits such as proper nutrition and exercise.

The OSMA Alliance's theme this year is "Strength in Unity." We are uniting with the OSMA's Physicians' Campaign for a Healthier Oklahoma by bringing the Extinguisher to our state on a permanent basis. Initially an AMA anti-smoking campaign, the super hero Extinguisher project was given to the AMA Alliance. The Extinguisher project is currently being implemented by the OSMA Alliance. Four Extinguisher costumes will be designed and made for use around our state. The OSMA Alliance will be able to lend the costumes to county Alliances by the next quarterly meeting.

Physicians have the option of positively impacting our state's health by communicating with their patients about healthy lifestyles and teaching them about wellness. Physician spouses have the opportunity to impact our state's health through the OSMA Alliance's many health projects. A united force of Oklahoma physicians and their spouses can make a tremendous difference toward improving healthy lifestyles in our state. Please get involved!

"A united force of Oklahoma physicians and their spouses can make a tremendous difference toward improving healthy lifestyles in our state."

The Last Word

Applications to Medical Schools Continue to Drop

According to the American Medical Association's annual survey, the number of applicants to the nation's 125 medical schools fell for the third consecutive year in 1999. Last year's freshman class, numbering 38,529 applicants, was down 6% from 1998 when there were 41,004 applicants. The largest drop in applicants was among men, who were down 9.1%; the number of women applicants fell by 2%. In addition, the survey also examined courses offered at medical schools last year and found that 82 schools (66%) had required classes that included instruction in alternative medicine, while 109 schools (87%) required courses that included cultural diversity education.

DEA Issues Guidelines to Avert Drug Abuser Scams

The US Drug Enforcement Administration has posted guidelines for healthcare practitioners to avoid being scammed by drug abusers on its Web site. The guidelines describe common characteristics of drug abusers (for example, assertiveness, unusual knowledge of controlled substances) and modus operandi often used in their efforts to obtain drugs (seeking services after normal business hours, pressuring practitioners by eliciting sympathy or guilt). The guidelines also summarize the "dos" and "don'ts" for practitioners. To read the publication, "Don't Be Scammed by a Drug Abuser," visit www.usdoj.gov/dea, select "Programs," then "Diversion Control." You will be redirected to a site where you can select "Publications," then "Informational Brochures," then select the publication by name.

Tobacco Advertising Still Prevalent in Doctors' Offices

A recent study of pediatric practices in Rochester, New York, indicates that fewer than 10% of those surveyed were actually free of tobacco advertisements, even though most practices had anti-smoking brochures or posters in their waiting room. Popular publications such as *Time* and *Newsweek* include cigarette advertising, and many physicians' offices receive magazines without subscribing or requesting them. Magazines that do not include any tobacco advertisements are available; for a list, visit www.viahealth.org/via_news/news2000/may/smokefree.htm.

FDA Targeting Illegal Prescription Sales Via Internet

The US Food and Drug Administration has issued warning letters to foreign-based Web site operators suspected of illegally offering to sell prescription drugs via the Internet. The cyber-warnings, the first of their kind used by the FDA to target those suspected of violating the Federal Food, Drug, and Cosmetic Act, outlined the nature of the alleged violations and requested a formal response, and explained the statutory provisions that govern interstate commerce of drugs in the US and warned that future shipments of products into this country might automatically be detained and refused entry. The FDA has indicated that it may also use this approach in its efforts to crack down on domestic Web sites conducting similar illegal activities. In addition, the FDA's Web site (www.fda.gov) contains information for consumers on purchasing prescription drugs and medical products online.

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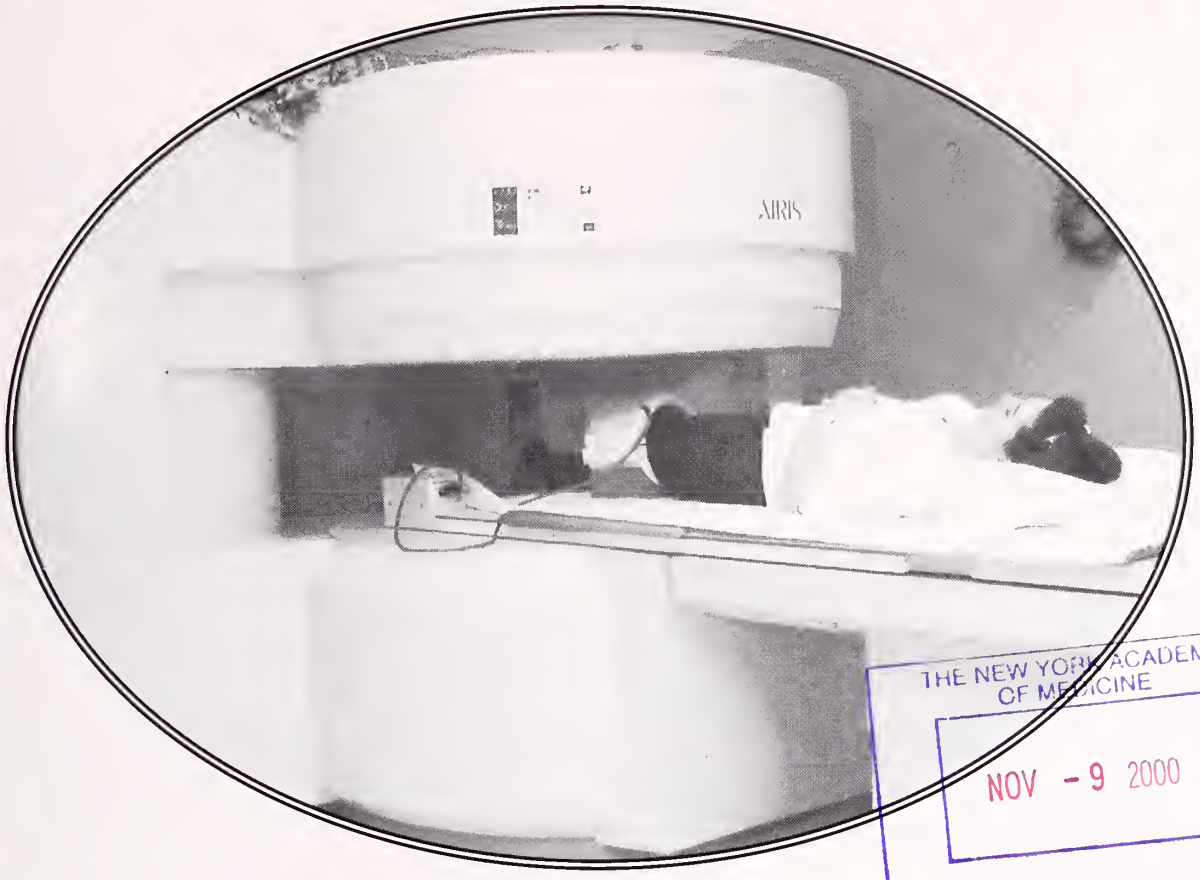
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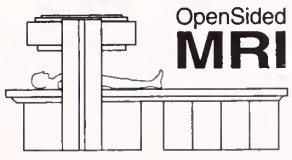
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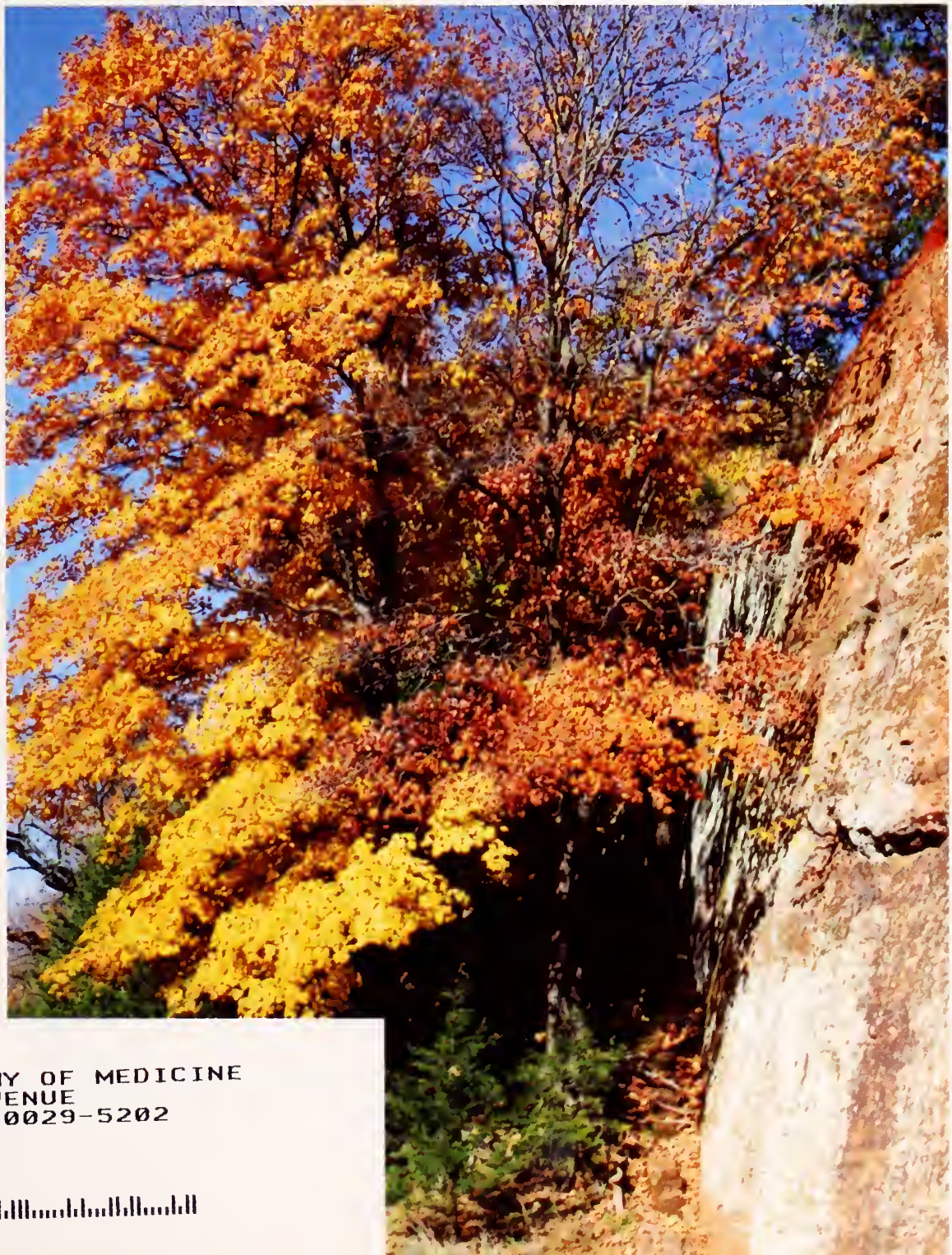
NSIDE:

Occult Quinine-Induced Thrombocytopenia 519

Violence in Adolescents 522

The State of the *State of the State's Health Report* 528

News 531



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NOVEMBER 2000 VOL. 93, NO. 11

EDITORIAL

On Healthcare Fraud... 515
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE

Covering the State: The Physicians' Liability Insurance Company 517
ROBERT J. WEEDN, MD, DUNCAN

SCIENTIFIC

Occult Quinine-Induced Thrombocytopenia 519
KIARASH KOJOURI, MD, OKLAHOMA CITY; JEDIDIAH J. PERDUE, OKLAHOMA CITY; PATRICK J. MEDINA, PHARMD, OKLAHOMA CITY; JAMES N. GEORGE, MD, OKLAHOMA CITY

SPECIAL

Violence in Adolescents: Leading Factors, Their Effects, and Possible Prevention 522
TITILOLA ODUTOLA, BDS, OKLAHOMA CITY; EDWARD N. BRANDT, JR., MD, PHD, OKLAHOMA CITY

COMMENTARY

The State of the *State of the State's Health Report* 528
GLENN P. DEWBERRY, MD, OKLAHOMA CITY

NEWS

Mowry, Moran Receive Presidential Citations, 531...Public Health Excellence Awards Given, 531...Update: Continuing Medical Education and Your Oklahoma License Renewal, 532

DEPARTMENTS

From the OSDH, 535...Letters to the Editor, 537...In Memoriam, 539...Obituaries, 539...CME, 542...Alliance, 543...The Last Word, 544

ABOUT THE COVER

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On Healthcare Fraud...

Have you noticed in your life that you have "buttons"—buttons that raise your blood pressure or make your face red?

As physicians we are all at risk for the micromanagement that is prominent in our society. When there is a management mishap or problem that involves a physician the headlines read "Physician Caught in This-or-That...News Update at 10," and folks flood to the story, mesmerized that a physician is involved.



It is always healthy to see our position a bit lower than the pedestal on which many have elected to put us.

Then comes the mail and with it come the constant reminders that the world out there watches each of us like a hawk. Take, for instance, my health insurance: my employer pretty well dictates what insurance I will have. Now, do not misunderstand me—I appreciate the benefit, but a recent experience did cause me concern. The legalese of the insurance contract and how they can pay just a fraction of the submitted bill have always impressed me. Euphemistically they are telling me that they have negotiated with my provider to give me the service at a reduced price.

These folks are really my friends—they are looking out for me.

Then again, maybe that is a perspective that I have because of years of having my fees lowered and contracted for discounts just to survive...

I recently received an envelope from the insurance company updating me regarding a previously submitted claim. There on the back of the envelope, printed in bold letters, was written: "When you observe Healthcare Fraud, call 1-800-REPORT-MD."

It angered me; it was a statement that said "when," not "if."

The most offensive thing to me is that we are talking about an industry that makes a profit through legalistic maneuvers to deny appropriate medical care—and they now have a unit to deal with healthcare fraud. Isn't this a bit like the fox guarding the hen house?

Then I read about the federal government's activity in this area. They have assigned a large contingent of FBI agents to the Office of the Inspector General for the purpose of seeking out healthcare fraud. Fraud that "pervades the Medicare system."

Seems I heard of this approach over a year ago. There hasn't been much action recently. I suppose the easiest way for me to do something illegal with the Medicare program would be for them to change the rules and regulations, burying "logical reason" as deep as possible. And when you go to research the law, it is always difficult to understand, it is always open to interpretation.

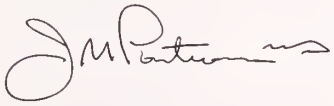
A fine system to work in.

One of my patients asked me the other day why Medicare put on their notification of remittance a reminder for the patient to call them if they believe that the charges were incorrect or excessive. "Doc, they are just asking for folks to sue you...why is that?"

I get red-faced and my neck veins distend when angered—I suppose it is from my Scotch Irish grandmother. It warns those around that I am ready to blow... I have tried to contain this genetic tendency to let things get under my skin, typically to no avail. Our society's micromanagement of physicians in an effort to stem perceived healthcare fraud is one of those things that gets under the skin and pushes my "button."

Where have we as a profession gone wrong? When did it become imperative that our profession be so scrutinized, so judged, and under so much suspicion? We have lost the ability to police our own and we fear retribution if we report something that does not appear appropriate. So now we abdicate this responsibility to the insurance companies and the federal government?

Somehow that doesn't strike me as an appropriate move...



J. Michael Pontious, MD
Editor-in-Chief

"The most offensive thing to me is that we are talking about an industry that makes a profit through legalistic maneuvers to deny appropriate medical care—and they now have a unit to deal with healthcare fraud. Isn't this a bit like the fox guarding the hen house?"

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA

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Covering the State: The Physicians' Liability Insurance Company

Another privilege that I've been afforded as President of the OSMA is membership on the Physicians' Liability Insurance Company (PLICO) Board of Directors. A little history is in order for those who are new to the OSMA.



PLICO is a wholly-owned, non-profit subsidiary of OSMA, and OSMA is the sole shareholder of this captive insurance company that was created in a crisis in 1970 when all private malpractice insurance companies ceased to write malpractice insurance for physicians in this state. As a result, OSMA incorporated and began operations of PLICO with borrowed funds, with individual assessments of all members. The result today is that the OSMA owns an extremely strong malpractice insurance company that has only Oklahoma physicians' best interests at heart. The Board and its six standing committees spend an entire weekend at least six times a year to make sure that you have the least expensive, most cost-effective, and highest quality malpractice insurance possible. Additionally, as you know, PLICO decided to write health insurance for its members, their families, and employees in the early 1970s.

The major standing committees of the PLICO Board and their functions are:

1. Loss Prevention, which studies ways to prevent litigation;
2. Claims, which works with our attorneys and makes recommendations about litigation;
3. Underwriting, which reviews malpractice coverage applications and makes recommendations;
4. Investment, which works with financial advisors to protect and grow PLICO assets;
5. PLICO Health, which works to determine health insurance policy premiums, etc.; and
6. Executive Committee, which holds the responsibility of determining agendas for Board Meetings and is empowered to act for the full Board when necessary.

All committee members are your colleagues and physician members of OSMA, and they work well with the professionals at C.L. Frates, the superb management company retained for day-to-day operations. As the least-experienced member of the Board, I'm personally in awe of the collective talent, expertise, and commitment of these physicians—all working on your behalf. No other malpractice insurance company anywhere else in the nation is like PLICO.

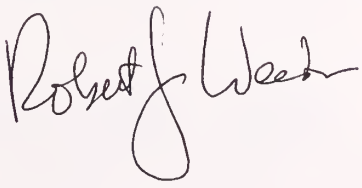
An out-of-state, for-profit competitor has now appeared in the market, offering lower premiums as a loss leader to try to get a foothold in Oklahoma. Experience with this company in adjacent states is revealing. The low premiums to get your business go up radically over time, especially if they can diminish competition in their market, ie, weaken PLICO.

In the final analysis, PLICO is financially strong and insures more than 4,000 of us. Its policy is better. Its premium is competitive. In order to keep the cost of our insurance lower than that in any other state we must continue to support our insurance company, PLICO.

A brief word about PLICO Health. Physicians, their families, and employees are medically sophisticated and tend to utilize health care services extensively; increased utilization results in increased cost of premiums, especially when hospital expenses, which are responsible for 50% of your premium dollar, are going up exponentially. Reinstatement of the time-honored concept of professional courtesy as part of our Oath would certainly help defray some of the increased cost and potentially increase our appreciation of each other.

Your PLICO Board is committed to providing quality health insurance to you and yours, but not at a loss—hence the recent increase in premiums and almost certainly more in the future. PLICO malpractice and PLICO Health Insurance are critical member services—please support them.

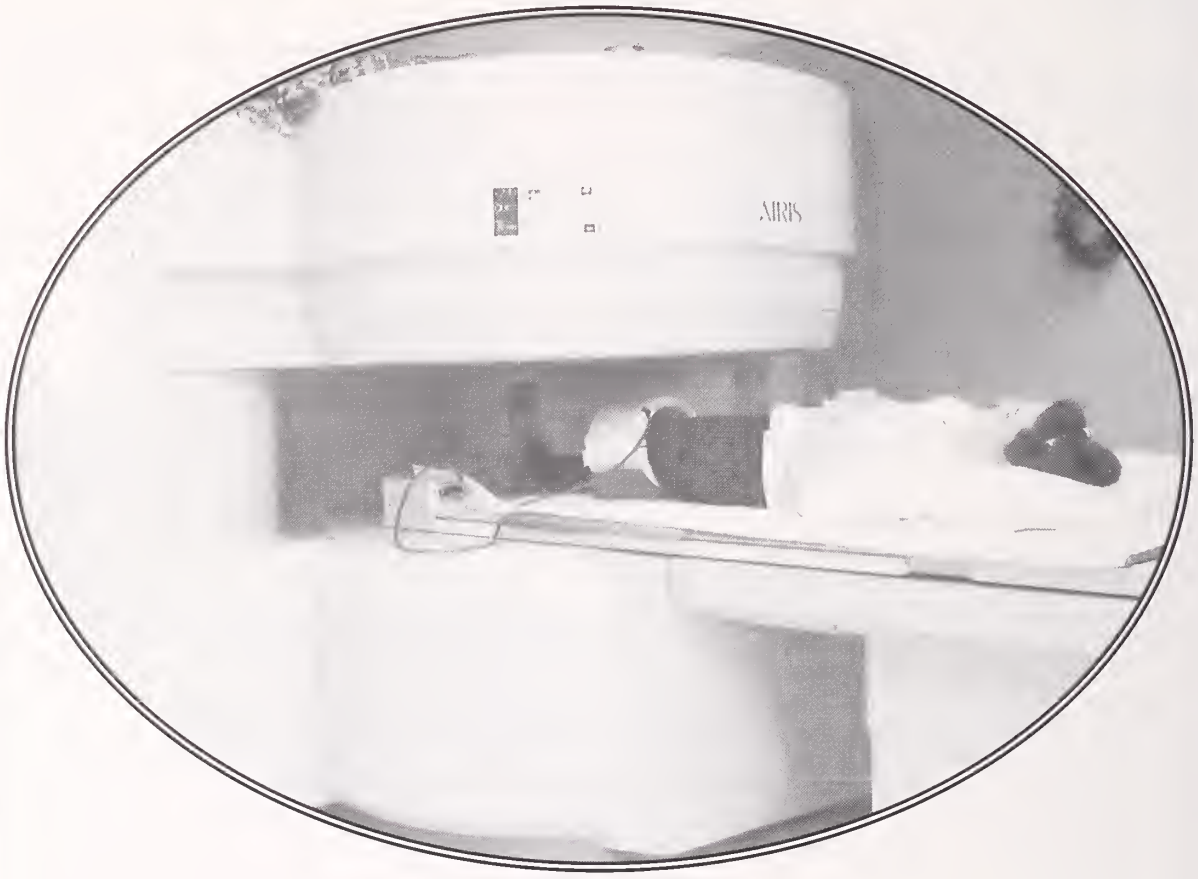
Finally, I'd like to wish you all a wonderful Thanksgiving—we have much for which to be thankful.



Robert J. Weedn, MD
OSMA President

> "As the least-experienced member of the Board, I'm personally in awe of the collective talent, expertise, and commitment of these physicians—all working on your behalf."

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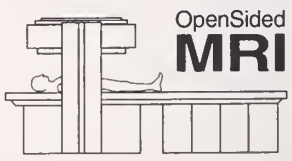
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Occult Quinine-Induced Thrombocytopenia

Kiarash Kojouri, MD; Jedidiah J. Perdue; Patrick J. Medina, PharmD; James N. George, MD

Quinine is universally used for the very common symptom of night leg cramps. Patients may not mention it among their medicines, since it is so commonly used and they regulate it themselves. A 68-year-old man suddenly developed extensive bleeding due to severe thrombocytopenia. The diagnosis was initially thought to be a recurrence of idiopathic thrombocytopenic purpura (ITP) that had initially occurred in 1992 and had required splenectomy. Drug-induced thrombocytopenia was also considered, and he was told to stop all of his medicines. Only after three subsequent episodes of severe, symptomatic thrombocytopenia over the next four weeks did he say, upon repeat questioning, that he had continued to take quinine for night leg cramps. Even after a strict warning, he took another quinine tablet that evening, which triggered his fifth episode of severe thrombocytopenia, and confirmed the etiology of quinine-induced thrombocytopenia. The diagnosis thrombocytopenia caused by common drugs can be difficult, requiring persistent, explicit questions.

Introduction

Drug-induced thrombocytopenia is common and potentially fatal. A recent systematic review evaluated all case reports describing drug-induced thrombocytopenia for the strength of evidence linking the drug as a cause for the thrombocytopenia: 98 drugs were described in 247 case reports with definite or probable evidence that the drug caused thrombocytopenia.[1] Quinidine is the most common drug causing thrombocytopenia; quinine is second most common.[1] A complete database describing all case reports of drug-induced thrombocytopenia is available on the website: http://moon.ouhsc.edu/jgeorge.

Direct correspondence to: James N. George, MD, University of Oklahoma Health Sciences Center, Hematology-Oncology Section, PO Box 26901, Oklahoma City, OK 73190

Even when physicians are alert for drug allergy as a cause for thrombocytopenia, the diagnosis may not be apparent, as in the case described below. The difficulty is that patients may not consider quinine and other common remedies as "drugs." In response to the question, "What medicines are you taking?" a patient may innocently omit medicines that he takes only intermittently for common symptoms.

Case Report

Mr. S., a 68-year-old white male, was admitted to a Kansas hospital intensive care unit on December 20, 1999, for the acute onset of extensive petechiae, purpura, and severe epistaxis. He had a past history of idiopathic thrombocytopenia purpura (ITP) for which a splenectomy was required in 1992. Mr. S. had had no bleeding symptoms and his platelet count had been normal since that time. In January 1999 he had a myocardial infarction that required coronary artery bypass graft surgery in March.

On initial evaluation it was assumed that the thrombocytopenia was a relapse of ITP. However, drug-induced thrombocytopenia was considered, and the patient was told to stop all of his medicines (glucotrol, clonidine, hydrochlorothiazide, aspirin, cayenne pepper pills for atherosclerosis, arthrx capsules for arthritis, and occasional quinine tablets for night leg cramps). On admission his platelet count was 2,000/µl (Figure 1); the remainder of his blood counts and other laboratory data were normal. He was started on methylprednisolone and insulin; intravenous immunoglobulin (IVIg) was given for three days. His platelet count responded to 44,000/µl on December 23, and he was discharged on prednisone and insulin. He had an acute exacerbation of mucocutaneous bleeding with a platelet count of 5,000/µl on December 28,

Table 1: Availability of Quinine, in Cinchona Bark Preparations, for Online Purchase at Selected Internet Sites.

Manufacturer	Active ingredient (stated by manufacturer)	Manufacturer's suggested uses	Internet site
Hyland	Cinchana Officinalis 3X, HPUS (Quinine)	"Leg Cramps"	www.gnc.com (also available at retail GNC outlets) www.wholefoads.cam www.vitaminshappe.cam Also available at Wal-Mart
Boiron	Cinchana Officinalis	"Hameapathic aptian far debility, fever, ar nose bleeding"	www.whalefaads.cam
Frontier	Cinchana Officinalis	"Headache and sinus relief"	www.whalefaods.com
Vitamin USA	Cinchana Officinalis - (Cinchana Bark)	"Lass af vital fluids, exhaustian fram excessive sweating, diarrhea, distended abdomen, gas"	VitaminUSA.com

Descriptions of these products were found on the Internet using the seorch terms "quinine," "cinchona," and "leg cramps." The active ingredients and suggested uses are taken directly from these Internet sources. Quinine is a derivative from the bark of the cinchona tree and is still obtained from this source

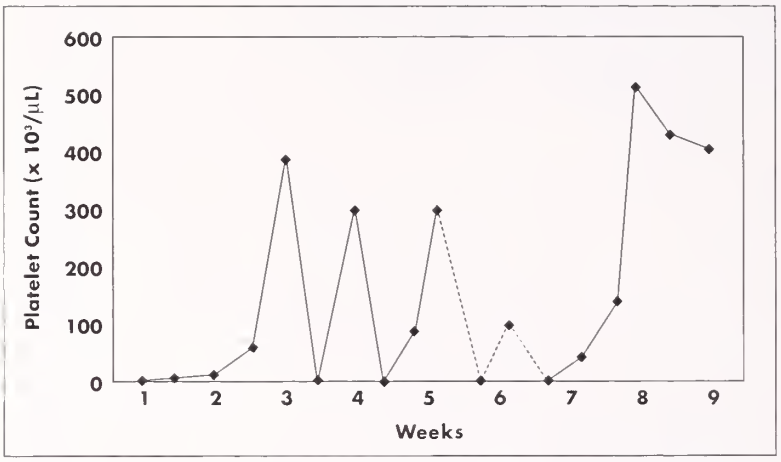


Figure 1. Clinical course of quinine-induced thrombocytopenia. The initial platelet count in this figure was on December 20, 1999. Each episode of thrombocytopenia was accompanied by severe mucocutaneous bleeding (petechiae, purpura, and epistaxis). For the fourth episode of acute bleeding, the patient did not see his physician; therefore, estimated platelet counts are represented by the broken lines. Although the patient recalled that he probably took quinine prior to each episode of thrombocytopenia, the only time that quinine ingestion was precisely correlated with the development of thrombocytopenia was with his fifth (and final) episode. The platelet count has remained normal.

again treated with three days of IVIg. His platelet count increased to 302,000/μl on January 3, 2000, but on January 6 he had his third acute episode of bleeding and thrombocytopenia, and was again admitted to the hospital, receiving IVIg for three days and also cyclophosphamide, 100 mg/day for ten days, in addition to the continued prednisone. His fourth episode occurred on January 15 with the acute onset of extensive purpura and epistaxis; however, this time he did not consult his physician. The symptoms of purpura and prolonged bleeding from his fingersticks for glucose measurements resolved within two days, on January 17.

On January 18 he was re-evaluated. Drug-induced thrombocytopenia was strongly suspected because of the course of repeated sudden, severe episodes of thrombocytopenia, each followed by prompt recovery to a normal platelet count. Mr. S. was asked what medicines he was taking. "None," he replied. "My doctors told me to stop all of my medications. I only take prednisone and insulin." Recognizing quinine as a common cause of drug-induced thrombocytopenia, he was asked if he had taken quinine in the past four weeks. "Yes, I have. But I only take it when I need it for severe leg cramps," he said. When asked why he had continued to take quinine when his doctors had told him explicitly to stop all medicines, he replied, "Well, I didn't think these quinine tablets could hurt me." He said that he had taken quinine tablets several other times in the past month. Although he could not relate the times exactly to the occurrences of thrombocytopenia, the evidence for quinine-induced thrombocytopenia seemed strong. Mr. S. said he had previously taken quinine for malaria in Okinawa during World War II, but he had not taken it again until April 1999 when he was given a prescription for quinine for night leg cramps. He took several tablets during the spring, summer, and fall of 1999. This information supported the original diagnosis of ITP in 1992.

Therefore, Mr. S. was told very firmly on January 18 that quinine was the cause of his recurrent severe thrombocytopenia, and that he should immediately throw away all of his quinine

tablets and never take one again. He was also told not to drink tonic water, which contains quinine, and to read carefully the labels of any over-the-counter medicines or health food supplements to be sure that quinine, or its natural form, cinchona, were not among the ingredients.

Three days later, on January 21, 2000, Mr. S. called to report that he had had another episode of severe bleeding, beginning on the morning of January 19 (Figure 1). He had seen his physician in Kansas; his platelet count was 4,000/μl and he was hospitalized and treated with IVIg and a platelet transfusion. He was asked, "Did you take another quinine tablet before this happened?" "Yes, I did. On Tuesday night (January 18). My leg cramps were real bad and I thought that just one tablet couldn't hurt me." Then he actually did throw away all of his quinine tablets!

Discussion

For 60 years[2] quinine has been the familiar remedy for night leg cramps, and leg cramps are a very common problem. In response to the question, "Have you had trouble with cramps in your calves or feet at night?" 276 of 490 (56%) outpatients surveyed at the Denver Veterans Administration Medical Center reported that they had. One-fourth of these patients reported daily cramps; another one-fourth reported the frequency to be one to four times per week.[3] Before 1995, quinine could be purchased without a prescription; that year the Food and Drug Administration banned the sale of all quinine-based, over-the-counter preparations because of lack of data to support the efficacy of quinine for leg cramps and because of reports of serious allergic reactions,[4] including deaths from thrombocytopenic bleeding.[5] However, the risk for acute thrombocytopenia due to quinine allergy is not limited to pharmaceutical preparations. The popular beverage "tonic water" contains about 8 mg/100ml of quinine, sufficient to cause severe thrombocytopenia with a single serving.[6] Also, quinine is the principal ingredient in alternative therapies and herbal preparations that are available at internet sites (Table 1). Although these preparations have not yet been documented to cause thrombocytopenia, the risk is apparent. However, one site (www.vitaminshoppe.com) markets the Hyland product with the following statement: "Working without contraindications or side effects, Hyland's Leg Cramps is safe for adults and can be used in conjunction with other medications." These products are widely discussed among people seeking information about remedies for leg cramps in internet "chat rooms."

The story of Mr. S. is instructive. The previous diagnosis of ITP clearly influenced the physicians' impressions when acute, severe thrombocytopenia occurred. The medical care was correct: a complete list of prescription and non-prescription medicines was obtained and Mr. S. was instructed to stop them all. The problem occurred when Mr. S. did not interpret these instructions to include quinine. This experience emphasizes that persistent and explicit questions may be required to diagnose drug-induced thrombocytopenia. ⓙ

The Authors

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Violence in Adolescents: Leading Factors, Their Effects, and Possible Prevention

Titilola Odutola, BDS; Edward N. Brandt, Jr., MD, PhD

Adolescent violence is a major public health problem. The factors influencing boys to become violent are now known; hence, physicians may now recognize adolescents who may become violent. Physicians can be involved in the prevention of violence by either counseling young adolescents who demonstrate factors that influence violence, or by referring those at-risk individuals to a counselor.

Introduction

Violence is the intentional use of physical force against another person or against oneself that either results in, or has a high likelihood of resulting in, injury or death.[1] It is one of the most pressing and intractable problems in the world today with consequences that are pervasive and highly damaging. Violence occurs in many forms, including suicidal acts as well as interpersonal violence such as rape, assault, child abuse, and elder abuse homicide. Poverty, unemployment, racism, and other injustices, as well as alcohol and drugs, contribute in complex ways to violent behavior. The epidemic of violence continues to be a leading cause of premature death, injuries, and disabilities, having a great impact on adolescents and children, particularly in minority communities: in 1991, the most common cause of death for African-American males 15 to 24 years was homicide secondary to gunshot wounds.[1]

Impact

Numbers alone cannot convey the magnitude of the psychosocial impact of interpersonal violence.[2] Families, neighborhoods, and entire communities have been decimated by the loss of so many young and potentially productive people through suicide, homicide, incarceration, and the adoption of violent means of conflict resolution. The all-too-common exposure of young Americans to acts of violence in their homes and neighborhoods leads to a desensitization toward violence as unacceptable. Failure to overcome these barriers leads to low self-esteem and problem behavior among individuals, and leads to a new generation of potential participants in acts of violence.

Adolescents are exposed to violent situations at home and school, and through TV, books, magazines, peer pressure, and other social forces; these violent acts can take the form of physical assaults (fist fights between youths), sexual assault, rape, homicide, suicide, etc. Of all the types of family violence, abuse of adolescents is perhaps one of the most overlooked. According to the National Center on Child Abuse and Neglect, adolescents experience a disproportionately high level of violence, including the most severe cases that result in serious injuries and death.

A lot of emphasis has been placed on the negative effects of television.[3] It is believed to be one of the main influencers of children and adolescents. With the advent of television in the 1950s, there was a subsequent doubling of the homicide rate. Children and adolescents exposed to long-term television viewing committed approximately half of the violent acts committed in the United States. In 1974, the US white homicide rate was 5.4 per 100,000, but by 1987, it had risen to 5.8 per 100,000. It is a casual factor behind a major proportion (approximately half) of rapes, assaults, and other forms of interpersonal violence in the United States. This can be attributed to the fact

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that violence, more often viewed as a social problem than a medical, political, or psychological problem, is basically the response to economic inequities with personal factors playing a secondary role.

Human growth and development has been enhanced by improved health care and nutrition, resulting in an earlier onset of puberty as well as increases in height and body size, yet the sexual and social maturation of behavior is delayed. We are, therefore, faced with biologically prepared but mentally and sexually immature adolescent children who are emotionally vulnerable and need to be aided, guided, and encouraged to examine and restructure their cultural, social, political, and ideological order surrounding them.

Violent behavior is usually due to some form of aggression. The remarkable thing about aggression is that it seems to start at an early age and increase with age, but then starts to wane after the age of 40. There is strong evidence that an adolescent growing up in a violent family tries to behave in accordance with the adult's way of behaving.[4] In a family background where violence is a common occurrence, adolescents grow up with violence among their siblings and parents. Each family has its own ways of handling disputes and disagreements; however, some resolve conflict by yelling, others by hitting, and still others by acting out in more obscure ways. There is no doubt that in some families there is more aggression, both verbally and physically, and adolescents coming from these families tend to be more aggressive and violent.

Studies indicate that violent, delinquent adolescent boys had six common background factors: harsh parental attitude and discipline; criminal parents; poor parental supervision; parental separation; daring behavior; and low IQ.[4] However, it is emphasized that the greatest difference between violent and nonviolent adolescents is the fact that violent adolescents were far more likely to have experienced cold, harsh parents and experienced separations from their parents in early years of their life. It appears that if adolescents are treated violently and are devoid of continuous care and love from the same adults, they tend to become violent. It has also been observed that although a large percentage of boys may commit a crime or two in their adolescent years, only a small fraction of them go on to become chronic offenders. The latter group becomes responsible for the majority of violent crimes.

Influencing Factors

There are three broad groups of factors that each individually have been thought to be a cause of violent behavior; more cautiously minded persons may assume that these factors interact in some yet-undetermined way to result in adolescent violent behavior. They are:

1. biological factors;
2. family deprivation; and
3. extrafamilial and sociological factors.

Biological Factors

There is some indication that the rates of mental retardation and mental instability are increasing; this increase has been found to parallel the acceleration in rates of violence.

Family Deprivation

Increased violence is seen as a result of family pathology.[5,6] The stresses on the family life are well established. The rising rates of divorce, unemployment, separation, and desertion may be a reflection of increased stress on family life. Interfamilial experience, like marital discord, father absence, repeated parental separation, lack of attachment, inconsistent discipline, as well as neglect and abuse of adolescent children, has a powerful impact on the socialization of adolescent. Adolescents who are unhappy in this environment may express this unhappiness through violent episodes.

Extrafamilial and Sociological Factors

The critical group of factors to explain increasing levels of lethal violence seem to be the political, economic, and social factors.[7] The adolescent socialization toward violence is a final result of their intellectual examination and its possibilities for them. Many conclude, sometimes precipitously and sometimes after considerable inspection, that given motivational demands—the number and complexity of which must be dealt with constructively—make it seem that there are no reasonable objectives or rewards in society for them. They resort to defeatist, give-up attitudes and compensatory face-saving tactics. This results in an increase in the number of adolescents who choose violence as their best alternatives. Drugs and alcohol have helped to accentuate violent acts in adolescent children. A drunken father who comes home and beats his wife is a bad example to the adolescent child.

Violence-related attitudes seem to play an important role as a psychosocial factor that influence the likelihood of violent behavior. A

study including youth from juvenile detention and school settings found that their beliefs about the acceptability of aggression and conflict management skills were each significant, independent predictors of aggressive behavior.[4] Violence-related beliefs were related to self-reported violent behavior in a study of low-income African-American youths. An intervention designed to change violence-related beliefs resulted in decreased incarceration for violent offenses. Attitudes favorable to violence involve: a belief that damaged self-esteem is most reliably repaired by fighting; a general comfort with physical aggression; a perception of guns and other weapons as exciting and stimulating; and a belief that guns and violence provide power and safety. Youth who do not express high levels of these attitudes are unlikely to own a gun.[5]

The general consequences of violence are economic devastation, destruction of one's culture, and lives and families shattered. In addition to the loss of life, the fragmentation of families, the displacement of populations, and the disruption of social and economic institutions, violence creates feelings of fear, pain, loss, grief, hatred, and sadness, and the dissolution of everyday forms of social language and experience occurs. These in turn result in a weakening of the society's moral fabric which leads to further domestic, civil, and gang-like conflicts and violence.

Exposure to violence also has serious mental health consequences for adolescents.[8] They have been described as experiencing constricted affect and "psychic numbing," displaying anxiety, depression, anger, dissociation, and behavioral misconduct. They also show impairment in cognition, including memory, learning, and school performance. Those that witness or experience extreme violence in their schools or home or communities may suffer post-traumatic stress disorder with symptoms of blunted affect, distractibility, and impaired social and emotional development.[9] Children and adolescents who witness violence often have impaired ability to control aggressive impulses, thereby increasing the risk of subsequent involvement in violent behavior. Parental responses to violence play an important part in shaping adolescents' different development outcomes. There are objective, quantifiable, and significant differences between families that produce violent teenagers and those that have normal adolescents. Family variables identified as being related to violent behavior by adolescents are: less agreement as a group; less agreement between mother and son; and a coalition between mother/father to influence choices within the group.

Solutions

Problems of violence can be resolved by being involved in violence prevention activities, including identifying, screening, and referring adolescents at risk for injury as a result of abuse, domestic violence, or assault. These individuals can be referred to youth mentoring or community/school outreach programs. Promotion of conflict-resolution skills should be part of the grade school curriculum. Provision of youth centers where children with troubled homes can interact with caring adults and role models should be provided. There should be education of the public that violence is preventable. A youth development program can be established for those that have missed out on educational opportunities.

Conclusion

Violence is a behavior and, like all other behaviors, it exists because it has been learned and is maintained because it is reinforced and rewarded. If there is a concern about violence in a community, then it is important to examine how that community functions, how children are brought up, how teachers manage the classroom, how sports are played, and how disputes are settled. We have to examine the kinds of models that are provided by people in power, such as the police, politicians, sportsmen, and film stars. What do our children watch on TV and read in papers and books? What is rewarded by our culture, and what is considered a virtue? If athletic events include fighting, if there is a standing diet of violence on TV, if being aggressive is considered a virtue, maybe it explains the amount of violence we have in our society. Roots of violence are not in our genes or blood, but in what we experience or observe.

For children to thrive, the environment must be able to meet their needs in all areas, including physical, social, and emotional. There are dire consequences of difficult and violent behavior if those needs are not met. If we wish to reduce the level of violence, we will have to bring up children differently, teachers will have to manage classrooms in other ways, and we will need a different kind of programming on television. We have to reduce aggression in our children by discouraging aggressive behavior and by making ourselves models of cooperative behavior for children to imitate. It is reasonable, therefore, to conclude that human beings by

nature are neither aggressive nor peaceful, but are molded into either type. This could explain the great differences in the amount of aggression present in different cultures. Violence is a behavior, and if we want to reduce it we have to develop a dislike for it—and make sure it is never appreciated or rewarded. At present, that is certainly not the case, and physicians can do much in their communities, and with their patients and their families.

The Authors

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Youth Violence in the United States

Rates of homicide among youths 15 to 19 years of age reached record-high levels in the latter half of the 1980s and continues to be among the highest ever recorded in the United States for this age group. Between 1985 and 1991, annual homicide rates among males ages 15 to 19 years old increased 154% (from 13 per 100,000 to 33 per 100,000), surpassing the rates of youths in the 25 to 29 years of age and 30 to 34 years of age groups.[1] Homicide rates for young males began to decline in 1994 and dropped 34% between 1993 and 1997 (from 34.0 per 100,000 to 22.6 per 100,000). In 1997, the rate of homicide among males ages 15 to 19 years of age was 22.6 per 100,000—a decline of 12.4% in one year.[2] Despite this encouraging trend, rates are still unacceptably high.

- In 1997, 6,146 young people ages 15 to 24 years old were victims of homicide. This amounts to an average of 17 youth homicide victims per day in the United States.[2]

- Homicide is the second leading cause of death for persons 15 to 24 years of age and is the leading cause of death for African Americans. In this age group, homicide is the second leading cause of death for Hispanic youths.[2,3]

- In each year since 1988, more than 80% of homicide victims 15 to 19 years of age were killed with a firearm. In 1997, 85% of homicide victims 15 to 19 years of age were killed with a firearm.[2]

- Arrest rates for weapons offenses among youths 10 to 17 years of age doubled between 1987 and 1993, then dropped 24% by 1997.[4]

- In 1997, 5.9% of students in a national survey reported carrying a firearm at least once in the previous 30 days. In 1995, this was true of 7.6% of students—a decline of 22.4% over the two-year period.[5,6]

- Between July 1992 and June 1994, 105 violent deaths occurred on or near school grounds or at school-associated events. The majority (81%) were homicides and firearms were used in most (77%) of the deaths. The violent deaths occurred in communities of all sizes in 25 states.

Key Risk Factors for Violence

One of the first steps toward preventing violence is to identify and understand the factors that place young people at risk for violent victimization and perpetration. Previous research shows that there are a number of individual and social factors that increase the probability of violence during adolescence and young adulthood. Some of these factors, clustered in four areas, include:

Individual History of early aggression Beliefs supportive of violence Social cognitive deficits	**Family** Poor monitoring or supervision of children Exposure to violence Parental drug/alcohol abuse Poor emotional attachment to parents or caregivers
Neighborhood Poverty and diminished economic opportunity High levels of transiency and family disruption Exposure to violence	**Peer/School** Associate with peers engaged in high-risk or problem behavior Low commitment to school Academic failure

Patient Handout #11

What Can I Do?

Educate yourself and others. Get the facts about youth violence. Find out what people around the country are doing to prevent violence. Youth violence is a very complex issue. Get the facts—then get involved.

Volunteer your time, talents, and efforts to preventing youth violence. Mentor a youth. Mentors provide role models for young people who have none, or they offer alternatives to negative role models. The attention and interest bestowed on youth by people who care enhance the youth's self-esteem and strengthens his or her ability to choose nonviolent methods to resolve conflict.

Offer your advice and voice your concerns. Your voice can be a powerful tool for change.

Learn new prosocial behaviors. Adults or parents who struggle with drug addiction or alcoholism and who perpetuate violent and abusive behavior provide poor role models for young people. Adult behavior greatly impacts young people. A great start in the prevention of youth violence is to have healthy, capable adults setting good examples for youth. You will be in a better position to help others once you help yourself.

Value parenthood and community. Value motherhood and fatherhood. Improving parenting skills and addressing factors that hinder a person's ability to effectively parent can improve how the parent and child interact. The improvement in this relationship may reduce the risk of childhood behavior problems and subsequent antisocial behavior that may predispose an individual to violence in later life. Working to strengthen marriages and relationships is a way to value parenthood and community.

Enlist the help of others in confronting this very important issue. You can be the catalyst to initiate change in your community. Reach out and organize others who share your vision of a safer environment for families.

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Source: Centers for Disease Control and Prevention: National Center for Injury Prevention and Control and the Youth Violence and Suicide Prevention Team. Available at www.cdc.gov.

Patient Handout #11

COMMENTARY

The State of the *State of the State's Health Report*

Glenn P. Dewberry, MD

Several aspects of this year's *State of the State's Health Report* require closer scrutiny and comment. The report is focusing on issues that have, historically, not been included in the arena of public health. In the past, the public health system has been concerned with problems ranging from contaminated food or water to communicable diseases that posed a threat to the community, such as tuberculosis and, presently, AIDS. The Oklahoma State Department of Health is obviously continuing in this traditional role. But between 1980 and 1990, following the lead of the federal Healthy People initiative, Oklahoma began to monitor "key health status indicators."

Two indicators that have received attention this year are tobacco abuse and obesity. The report's emphasis on tobacco abuse and obesity is, I am sure, well-intended, but even though smoking and overeating are health risk factors for the individuals who smoke and/or overeat, these behaviors are not a threat to the public in the same manner as certain behaviors of HIV-infected persons. Yet, HIV infection is not mentioned in the body of the report. The focus on age-adjusted mortality from all causes implies a very expanded role for the Department of Health by creating the impression that the Department of Health will somehow be able to address all causes of mortality in the state. The report notes the correlation between poor health outcomes and low socio-economic status, but it fails to adequately develop this important issue[1] and fails to mention support for economic reform and economic development efforts that would bring an improvement in this very significant problem in Oklahoma.

The report continues to be enamored with the promotion of universal health insurance, which is synonymous with government-controlled health care. I expressed concern[2] about the 1997 report[3] because it appeared to be advocating universal health insurance coverage. Dr. Deckert's response[4] to my concerns stressed that their report spoke "to the need of assuring 'access to quality health care services for Oklahomans'. It does not speak to how such assurance could be or should be obtained." Apparently he would disagree with the position that the only way to accomplish universal health care coverage is through imposing a government-controlled system. His response does little to reassure me, however, because in it he incorrectly quotes his own report that actually says "We need to assure access to quality health care services for *all* (italics mine) Oklahomans." This may appear to be an unimportant and miniscule detail, but those who closely follow the public debate regarding health care reform in this country will appreciate the significance of the word "all" either being present or being absent in a phrase concerning access to care in a report issued by a governing body, such as the State Board of Health.

In its discussion of the uninsured in Oklahoma, this year's report uses all-too-familiar rhetoric that gives credence to the idea that implementation of universal health insurance coverage would result in better screening and treatment of diseases like breast cancer, cervical cancer, and heart disease. It is very important to note that research does not support this position. In a 1994 study, Katz and Hofer[5] compared breast cancer screening and cervical cancer screening in Canada and the United States. They found that "Papanicolaou test and clinical breast examination rates were similar between countries, but mammography rates were two to three times

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higher in the U.S. across all age groups...Despite the long-time presence of universal insurance coverage in Ontario, the disparities in the use of cancer screening procedures by the poor were similar to the United States. Universal coverage is not sufficient to overcome the large disparities in screenings across socioeconomic status demonstrated in both countries."

Also in 1994, Mark and colleagues studied the use of medical resources and quality of life after acute myocardial infarction in Canada and the United States.[6] They found that "The Canadian patients had more cardiac symptoms and worse functional status one year after acute myocardial infarction than in the U.S. patients. The Canadian patients also underwent fewer invasive cardiac procedures and had fewer visits to specialists physicians. These results suggest, but do not prove, that the more aggressive pattern of care in the United States may have been responsible for the better quality of life."

I offer these observations in the spirit of constructive criticism, but also because I am concerned about the trend that is emerging among those who have been strong advocates of government-controlled health care in the United States. Having failed in their full-scale frontal attack on American medicine in the early nineties, they are now working diligently to create the impression that the quality of health care in America is very poor. A recent report[7] from the World Health Organization entitled *The World Health Report 2000: Health Systems—Improving Performance* (http://www.who.int) edited by Dr. Philip Musgrove found that the United States was ranked 37th in the world for quality behind Canada, which ranked 30th, the United Kingdom, which ranked 18th, Spain (7th), Italy (2nd), and France, which ranked first in quality of service in the world. E. Richard Brown, director of the Center for Health Policy at the University of California-Los Angeles, in response to the report, was quoted as saying, "the US is woefully lacking" as proven by the 40 million uninsured Americans amid a patchwork of private insurance and government programs. Uwe Reinhardt, Princeton University health economist, stated that while good at expensive, heroic care, Americans are bad at the low-cost preventive care that keeps Europeans healthy.

In 1998, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry declared an urgent need to improve the quality of care provided to Americans.[8] President Clinton's response to the recent report regarding medical errors and the current attack on physicians by President Clinton's Department of Health and Human services for "fraud and abuse" in the context of E&M coding are other examples. If the public can be convinced that the quality of health care in America is as bad as President Clinton would like for them to believe, then the "solution" of implementing government-controlled health care will not be long in coming. Oklahoma physicians must take this into consideration when reviewing reports and recommendations from various government entities.

It seems unusual that, in a public health report concerned with age-adjusted mortality from all causes, there is no mention of how Oklahoma is doing in the realm of HIV infection and AIDS. In 1993, the Centers for Disease Control (CDC)[9] reported HIV infection as a leading cause of death among young adults (25-44 years of age) in many US cities; in that same year, Dr. Deckert was quoted as saying, regarding the HIV/AIDS issue, "the elements of a potentially expanding epidemic are present in Oklahoma." This year's report included as appendices specific data making up the "Health Status Profile" for each county. In the section on communicable diseases, the rates of the various illnesses for 1998 were presented, except for HIV/AIDS. These numbers were not presented as rates, but as the "average annual AIDS cases (1983-1998)" and "average annual HIV cases (1988-1998)." This approach, of course, mixes the numbers of cases in the late eighties, which were small, with the current numbers, which tends to deflate the significance of the current situation.

In looking at the rate of new cases of AIDS from 1993 to 1999, one sees a downward trend—which is to be expected because of treatment of HIV infection, which is delaying the progression to AIDS. In looking at cases of newly HIV-infected persons, one sees a 1.7% increase between 1993 and 1994, a 9.8% increase between 1994 and 1995, a 6.2% increase between 1995 and 1996, an 11% increase between 1996 and 1997, and an 8.3% increase between 1998 and 1999. The Department of Health has explained to me that these increases are the result of more aggressive surveillance on their part, and so while they affirm that the general trend of newly HIV-infected persons is trending upward at a steady rate, it is not increasing in the dramatic way these figures would indicate. The important point is that the report seems to be attempting to mini-

mize this very significant public health problem by reporting the numbers differently than the way the other communicable diseases are being reported. This is inconsistent with the stated goal of the report, which is to inform Oklahomans regarding the behaviors that are putting them at risk for premature death from preventable disease. Tobacco addiction and obesity are sources of health risks for the individual, but in comparison to the HIV epidemic, they pose essentially no risk for others in the community around them. Therefore, to emphasize these two problems while ignoring HIV/AIDS in a public health report is an example of incorrect priorities.

Expanding the role and responsibility of the State Department of Health to include addressing all causes of mortality, promoting health insurance for all, and preventing smoking and obesity when traditional public health problems are, themselves, exceedingly challenging and are, as yet, unresolved, seems misguided. The recommendation to engage others in finding solutions for these problems by "decentralizing" the State Department of Health by fully implementing the *Oklahoma Public Health Innovation Plan* provides little hope of any practical benefit. Focusing on implementing more effective public health policies based on public health principles to address serious public health problems seems to be a better place to start. Diffusing this responsibility to "community partners," who are supposed to somehow discover solutions through focus groups, seems to be very unrealistic. The State Board of Health should turn its attention to the serious public health issues that pose a threat to Oklahoma communities rather than searching for new and different mountains to climb.

The Author

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Editor's Note: An article of response from the Board of Health of the Oklahoma State Department of Health will be published in an upcoming issue of the *Journal*. — JMP

Mowry, Moran Receive Presidential Citations

John D. Mowry, MD, of Tulsa, and Willard B. Moran, Jr., MD, of Oklahoma City, received presidential citations from American Academy of Otolaryngology president John Campbell, MD, of Tulsa, during the specialty association's recent annual meeting in Washington, DC.

Dr. Mowry has served as President of both the Oklahoma Academy of Otolaryngology and the Tulsa Surgical Society. Currently in private practice, Dr. Mowry has also instructed residents and medical students as a clinical assistant at the University of Oklahoma School of Medicine.

Dr. Moran has chaired both the Board of Governors and the Committee on Sleep Disorders for the Academy; he currently serves as the Coordinator for Socioeconomic Affairs. In addition, Dr. Moran has been a member of the Board of Directors of the Oklahoma County Medical Society.





Dr. John Mowry (left) and Dr. Willard Moran (below) receeive presidential citatious from Dr. Johu Cauphell, President of the Ameriean Aeadeuy of Otolaryugology—Head aud Neck Surgery.

Photos courtesy the Ameriean Aeadeuy of Otolaryugology—Head aud Neck Surgery Foundation.

Public Health Excellence Awards Given

OSMA physician members were recently recognized by the University of Oklahoma College of Public Health and the Public Health Alumni Association during the fifth annual Public Health Excellence Awards on November 3, 2000. Excellence Awards for Outstanding Individual Achievement in Public Health were awarded to:

- Harold R. Belknap, MD, of Norman, for his volunteer work in establishing Medical Explorer Scout Post #901 and the creation of the Gomer Jones Cardiac Center;
- James Michael Crutcher, MD, MPH, of Oklahoma City, for his efforts to improve the capacity of the Oklahoma State Department of Health to detect, investigate, and prevent infectious diseases in Oklahoma;
- Gordon H. Deckert, MD, of Oklahoma City, for his involvement in developing the first *State of the State's Health Report* in 1997 and formation of the Oklahoma Consortium for Improving the Health of Oklahomans;
- Robert J. Weedn, MD, of Duncan, who developed the concept for and has served as Chair of the OSMA's Physicians Campaign for a Healthier Oklahoma Task Force; and
- Edward Scovill, MD, and Dona Veal, MD, both of Ponca City, for their volunteer work in Kay County's community clinic.

In addition, the Oklahoma County Medical Society received an Excellence Award for Outstanding Public Health Program by Agency, Organization, or Community Group for its Schools for Healthy Lifestyles program, which reaches an estimated 13,000 students, parents, and school staff to a health preservation and prevention philosophy.







Drs. James Crutcher (left), Gordon Deckert (eeuter), aud Gary Strebel (right, ou behalf of Dr. Robert Weedn) accept awards for Outstauding Individual Achieveuent in Public Health from the University of Oklahoua College of Public Health and the Public Health Alumni Assoeiation.

Update: Continuing Medical Education and Your Oklahoma License Renewal

The following outlines the options available to physicians to meet the mandatory CME requirements for an Oklahoma medical license:

1. If you obtained and have documentation for 150 hours of CME in any medical topic (specialty) in the previous three (3) years from your renewal date. At least 60 hours have to be Category I and the rest can be in Category II as defined by the American Medical Association.

2. If you possess a current certificate for the American Medical Association Physician Recognition Award (AMA-PRA) covering the previous three years.

3. If you received your initial specialty board certification or recertification in an American Board of Medical Specialties specialty during the three years prior to your renewal date. This option will suffice for the total 150 hours.

4. If you were in a qualified residency or fellowship program during all or part of the three years prior to your renewal date, each year is equal to 50 hours of Category I. (For example: If you were in a residency in 1997, then in practice in 1998 and 1999, you would have 50 hours of Category I earned in 1997; you would need an additional 10 hours of Category I and 90 hours of Category II in 1998 and 1999.)

5. Through reciprocity, a standard AMA-PRA certificate can be provided to physicians who have met the CME requirements of the following organizations. Proof of membership in one of these during the three-year reporting period (1997, 1998, 1999) would meet the Oklahoma requirement.

American Academy of Dermatology
American Academy of Family Physicians
American Academy of Ophthalmology
American Academy of Pediatrics
American College of Emergency Physicians
American College of Obstetricians and Gynecologists
American College of Preventive Medicine
American Psychiatric Association
American Society of Anesthesiologists
American Society of Clinical Pathologists/College of American Pathologists
American Society of Plastic and Reconstructive Surgeons
American Urological Association, Inc.
California Medical Association
Medical Society of New Jersey
Medical Society of Virginia
National Medical Association

How to be CME Compliant

The CME Law:
The Oklahoma Board of Medical Licensure & Supervision has made some positive modifications to the original CME rule; the following outlines current CME law, which took effect earlier this year:

Subchapter 15. Continuing Medical Education
Section 435:10-15-1. Continuing medical education
(a) **Requirements.**
(1) Effective July 1, 2000, each applicant for re-registration of licensure shall certify every three years that he/she has completed the requisite hours of continuing medical education (CME).
(2) Requisite hours of CME shall be one hundred fifty (150) hours within the preceding three (3) years of which sixty (60) hours will be Category I as defined by the American Medical Association/Oklahoma State Medical Association/American Academy of Family Physicians or other certifying organization recognized by the Board.
(3) Newly licensed physicians and physicians whose licenses have been reinstated will be required to begin reporting three years from the date of licensure/reinstatement.

(b) **Exceptions/verification.**
(1) Exceptions from the requirement shall be:
(A) Medical doctors in residency and fellowship programs.
(B) Holders of current American Medical Association Physician Recognition Award (AMA-PRA) or its specialty equivalent.
(C) Medical doctors who have obtained their initial specialty board certification or recertification, during the three-year reporting period, by an American Board of Medical Specialties (ABMS) specialty board or a non-ABMS specialty board previously approved by the Board of Medical Licensure and Supervision.
(2) The Board staff will, each year, randomly or for cause select applications for verification that all CME requirements have been met. Physicians choosing to use programs other than the AMA-PRA must submit additional documentation on request as evidence that the compliance with CME requirements have been met in the specified time period.

(c) **Compliance.**
(1) Failure to maintain such records rebuts the presumption that CME requirements have been completed.
(2) Misrepresenting compliance with CME requirements constitutes a fraudulent application.

Source: Added at 14 Ok Reg 1413, eff. 5-12-97; Amended at 17 Ok Reg 1351, eff 5-11-00.

The following is a list of some details to help you to maintain CME compliance.

CME Documentation:
You will not have to send or attach your CME documentation, records, certificates, etc., at the time of your licensure renewal. When your license number is audited, you will be required to show proof of your CME documentation.

CME Compliance:
A. In 2000, if your active medical license renewal date was prior to July 1st, then you will not be asked about the CME requirement until your renewal date in 2001. In other words, you have another year before you will have to answer the CME question. The 150 hours of CME is always for the preceding three (3) years from the renewal date. In this case, 1998, 1999, and 2000, up to your renewal date in 2001.

B. In 2000, if your active medical license renewal date is July 1st or after, then you will have to answer the question, "Have you met the CME requirement of 150 hours in the previous three-year period?" on the renewal form (the three-year period being 1997, 1998, and 1999, up to your renewal date in 2000).

Note: Once you answer your first renewal question on CME, you will not be asked again until another three-year cycle. For example, if you renew in September 2000 and you respond to the CME question for 1997, 1998, 1999, and up to September of 2000, you will not be asked again about CME for renewal until September 2003. Notice that the first cycle allows for more time than an exact three years to give the benefit of ensuring the required 150 hours.

New License Applicant:
If you are a first-time applicant for a medical license in Oklahoma, you will not be asked about CME until three (3) years from the date your license application is approved and issued, which will become your annual renewal date.

Reinstated Licenses:
If you are reinstating your license in Oklahoma, the renewal date of your previous Oklahoma license remains the same, regardless of the date your license is reinstated (this has always been Board policy). You will not be asked about CME until three (3) years from your renewal date. For example: Your license is reinstated in November 1999, but your renewal date from your previous Oklahoma license was April of each year. You would not be asked about CME until three years from April 2000, which would be April 2003. Reinstatements following a Board-ordered revocation or suspension may have a CME requirement imposed by the Board as a stipulation of reinstatement.

CME Audits:
While you do not have to send in CME documentation with your renewal application, the Board will conduct random audits on a number of licensees. If your license number is selected for an audit of CME compliance, you will receive a letter from the Board asking you to send in all documents you claim meet the CME law for the time period in question. If you have the AMA Physician Recognition Award (PRA) or its specialty organization equivalent, verification of that will suffice. Initial specialty board certification or recertification can be utilized to meet the CME requirement one time, as long as it was achieved during the three-year reporting period. Otherwise the 60 hours of Category 1 have to be supported by a certificate of completion; the 90 hours of Category 2 can be a chronological log of CME activities (e.g., journal articles read, consultations with medical peers, use of electronic databases in patient care, medical writing, non-Category 1 seminars and lectures; see page 4 of the AMA-PRA information booklet).

CME Exemptions:
Who is exempt from the CME law? Only the following:
1. Those in full-time residency and fellowship training (1 year of training=50 hours of Category 1 CME); and
2. Non-licensed retired physicians, including physician emeritus status.

Those not exempt are: military physicians (Oklahoma-licensed); federal service physicians (Oklahoma-licensed); Indian Health Service physicians (Oklahoma-licensed); part-time or adjunct faculty (teaching hours=Category 2 hours); retired physicians that maintain a full Oklahoma license; physicians practicing out of state who maintain an Oklahoma license; physicians with an Oklahoma Special License (non-training); research physicians; managed care medical directors with an Oklahoma license; administrative medicine physicians; and full-time medical school or residency faculty.

CME Non-Compliance:
A physician that misrepresents compliance with the CME requirement on an application (renewal) and through an audit is found to be in non-compliance may be cited for filing a fraudulent application and unprofessional conduct. If found guilty, the physician could be disciplined by the Board, which is reportable to the National Practitioner Data Bank.

The Medical Board Members' View:
Continuing medical education is readily available to physicians today through multiple resources. The CME law is a valid and reasonable effort to keep medically informed. Therefore, intentional disregard and non-compliance will be considered a serious violation of unprofessional conduct.

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SIDS in Oklahoma: Is the "Back to Sleep" Message Reaching Everyone?

Peggy Byerly, MA, Oklahoma SIDS Coordinator, Oklahoma State Department of Health;
Paul Patrick, MPH, Women's Health Program Consultant, Oklahoma State Department of Health

Sudden Infant Death Syndrome (SIDS) is defined as "the sudden death of an infant under one year of age, which remains unexplained after a thorough case investigation by the police and the Medical Examiner's Office, including the performance of a complete autopsy, examination of the death scene, and a review of the clinical history."

SIDS is the leading cause of death among infants from one month to one year of age. Approximately 0.7 infants per 1,000 die of SIDS each year in the United States, resulting in 3,000 to 4,000 infant deaths. In Oklahoma, approximately 50 to 60 SIDS deaths occur annually, with a disproportionate number of infants affected being African American and American Indian.

Researchers have found that one of the most important ways to reduce an infant's risk of dying of SIDS is to put the infant to sleep on his or her back. In 1992, the American Academy of Pediatrics (AAP) released a statement recommending that all healthy infants be placed on their backs to sleep. A national campaign ("Back to Sleep") was launched in 1994 to promote supine positioning during sleep.

SIDS deaths in the United States have declined 43% between 1992 and 1997, saving the lives of nearly 2,000 infants each year. Oklahoma has noted a 21% decline from 1994 to 1999 (Figure 1).

Since the inception of the "Back to Sleep" campaign, the rate of total SIDS deaths has dropped in Oklahoma; however, the decline has not been consistent among African American and American Indian infants (Figure 2). Work remains to reach Oklahoma's minority populations with the "Back to Sleep" message.

Health researchers have found that infants in child care are more likely to be put to sleep on their stomachs. Many childcare providers have not heard of the AAP's recommendations on sleep position and continue to put babies to sleep on their stomachs. This is particularly dangerous for infants who normally sleep on their backs as they face an 18-fold increase of dying of SIDS if they are placed in the prone position to sleep. The Oklahoma SIDS Program, Oklahoma State Department of Health, is working with the Department of Human Services Division of Child Care on a statewide "Back to Sleep" mailing. This mailing will go to all licensed child care facilities and will contain a letter about SIDS and a "Back to Sleep" brochure that emphasizes the importance of putting infants to sleep on their backs.

Efforts must continue to increase public awareness about the dangers of prone sleeping for infants. ALL parents and caregivers of infants need to hear the "Back to Sleep" message, with a concerted effort to reach the

Figure 1. Sudden Infant Death Syndrome: Oklahoma, 1994-1999

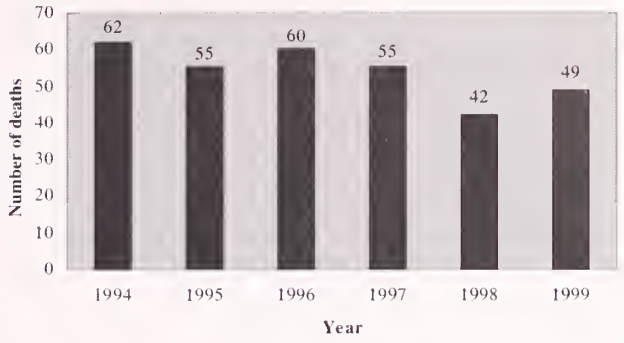
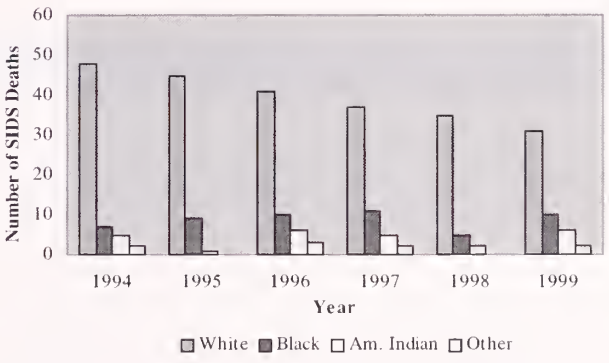


Figure 2. Sudden Infant Death Syndrome by Race: Oklahoma, 1994-1999



African American and American Indian communities. Physicians, nurses, hospitals, child care educators, clinics, and county health departments should assist in the education and promotion of placing infants to sleep on their backs.

As part of the "Back to Sleep" message, the Oklahoma State Department of Health suggests physicians offer the following recommendations to their patients:

- Place infants to sleep on their backs.
- Infants should never sleep on waterbeds, sofas, soft mattresses, or other soft surfaces.
- ***Do not*** place soft materials like pillows, quilts, comforters, sheepskins, and stuffed toys near sleeping infants.
- ***Do not*** expose infants to cigarette smoke before or after birth as this doubles a child's risk of dying of SIDS.

· If possible, encourage mothers to breastfeed their babies. Breastmilk helps keep their babies healthy.
· Only place infants on their stomachs when they are awake and can be supervised. This is important for developmental purposes and to help prevent flat spots from forming on the back of infants' heads.

The national "Back to Sleep" campaign is developing new brochures and outreach materials designed for minority populations. Physicians can request these materials directly from the "Back to Sleep" campaign.



For more information, contact the following:

OSDH SIDS Program
Oklahoma State Department of Health
Maternal and Child Health Service
Child and Adolescent Health Division
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Phone: 405/271-4470

Oklahoma SIDS Alliance
P.O. Box 12282
Oklahoma City, OK 73157
Phone: 800/248-7437

National Sudden Infant Death Syndrome
Resource Center
2070 Chain Bridge Road, Suite 450
Vienna, VA 22182
Phone: 703/821-8955 ext. 249

Back To Sleep Campaign
NICHD/Back to Sleep
31 Center Drive, Room 2A32
Bethesda, MD 20892-2425
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Letters to the Editor

To the Editor:

I am writing re: the editorial in the July 2000 issue of our *Journal*. At a time when OSMA leadership is trying very hard to be proactive, to be more responsive to our members, and to involve younger physicians in our Association, I am surprised that you find "what is happening" to be "disappointing and disturbing."

I do agree that it is a "sad fact" that many of the membership are ignoring the information we provide and that some may even feel that what we are doing is irrelevant. I would hope that those who were not on the side of unification, increased dues, etc., would not take their ball and go home, but would continue to work with us to make changes where necessary to make our Association a better one.

We must have rules and regulations and I certainly do not agree that what we have created is evil. I think we are very concerned with, and certainly tolerant of, the changing moods and desires of our members. I would suggest that we are not protective of the "status quo."

I do not understand your statement regarding the "entrenchment of the current power." We are making every effort to involve the "outsiders." Through our letters, articles in the *Journal* and newsletter, through our visits to the counties, and recent improvements in our Internet communications, we are asking non-members, young physicians, residents, and students to increase their OSMA involvement in and input into our activities.

I agree that many of the leaders are "gray-haired." We find that when many of our members reach that point where their practice is established and their children are raised and they have more time to be involved...the gray is setting in! I don't know what to do about this, except maybe to suggest we use a little darker tint to our hair care procedures.

As to the residents' and students' "confusion in understanding the relevance of the organization," I would again disagree. More than 400 residents in the state are members of the OSMA and AMA. Over 90% of the first-year students in 1999 have become members and the student council is quite active in organized medicine. There are student representatives on most of our councils and committees.

I think all the above shows that good things are happening. We are open to suggestions and promoting change where it is needed. The Task Force on Governance is looking into many areas of our Association and will be recommending changes to help make the OSMA "in tune" with the changing times. I think this is "the nature of our professional organization."

I hope that you will work with us to make the OSMA more and more an organization that will benefit all the physicians of Oklahoma.

Boyd O. Whitlock, MD
OSMA Immediate Past President
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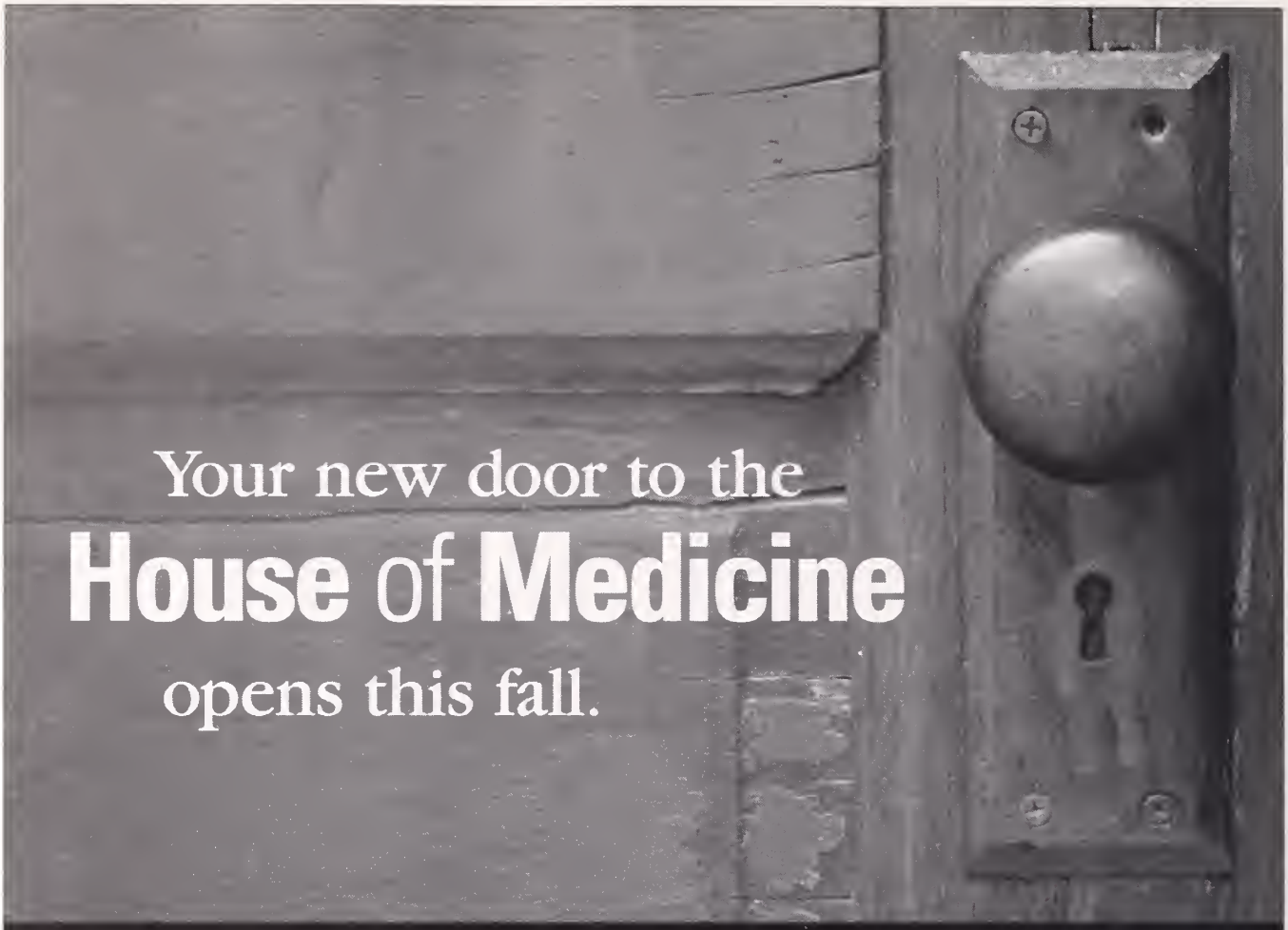
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Everett L. Wiggins, MD
1928-2000

Everett L. Wiggins, MD, died September 10, 2000. Dr. Wiggins was born January 19, 1928, in Sallisaw; following graduation from high school, he entered the United States Army, serving from 1945 to 1948. Dr. Wiggins received his medical degree from the University of Oklahoma School of Medicine in 1954 and an ophthalmology degree from the University of Oklahoma Medical Center in 1963. Dr. Wiggins was a member of the Oklahoma State Medical Association.



Hans Peter Franz Norberg, MD
1941-2000

Hans Peter Franz Norberg, MD, died October 6, 2000. Born in Tulsa on January 1, 1941, Dr. Norberg received his medical degree from the University of Oklahoma in 1969. From 1971 to 1973, he served as Senior Medical Officer at the US Naval Communications Station in the Philippines, reaching the rank of Lieutenant Commander. Dr. Norberg was a member of the Oklahoma State Medical Association.



John F. Gray, Jr., MD
1913-2000

John F. Gray, Jr., MD, died October 19, 2000. Born October 6, 1913 in Moravia, Iowa, Dr. Gray received his medical degree from the University of Iowa School of Medicine in 1943. He served in the United States Army Reserve from 1943 to 1946, having achieved the rank of Captain upon discharge. Dr. Gray was named a life member of the Oklahoma State Medical Association in 1983.



Jerry R. Hordinsky, MD
1942-2000

Jerry R. Hordinksy, MD, died October 20, 2000. Dr. Hordinsky was born August 3, 1942, in Kalush, Ukraine, and traveled to the United States with his parents in 1947. He received his medical degree from Northwestern in 1967. Dr. Hordinsky served in the United States Army from 1968 to 1971, and served in NASA from 1973 to 1980. In 1999 Dr. Hordinsky was named a life member of the Oklahoma State Medical Association.



Arthur F. Elliot, MD
1922-2000

Arthur F. Elliot, MD, died October 24, 2000. Born May 9, 1922, in Buenos Aires, Argentina, Dr. Elliot moved to the United States with his parents at the age of 14. He received his medical degree from the University of Oklahoma School of Medicine in 1945 and served in the United States Navy from 1946 to 1947. Dr. Elliot was a past president of the Oklahoma County Medical Society and a life member of the Oklahoma State Medical Association.

Thornton Kell, MD
1911-1999

Thornton Kell, MD, died July 15, 1999. Born July 13, 1911, in Welch, West Virginia, Dr. Kell received his medical degree from the University of Georgia in 1937. In 1982 he was named a life member of the Oklahoma State Medical Association.

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Oklahoma City

Integris Bass Baptist Health Center
Enid

Integris Southwest Medical Center
Oklahoma City

Jane Phillips Medical Center
Bartlesville

Mercy Health Center
Oklahoma City

Norman Regional Hospital
Norman

Orthopaedic & Reconstructive Research Foundation
Oklahoma City

St. Anthony Hospital
Oklahoma City

Saint Francis Hospital
Tulsa

St. John Medical Center
Tulsa

Shawnee Regional Hospital
Shawnee

Stillwater Medical Center
Stillwater

Valley View Hospital
Ada

Course offerings from OSMA-Accredited Institutions

Deaconess Hospital: Yvonne Curtright 405/604-4979

Nov. 2, 9, 16, 30	Cancer Conference	12:15 pm	1 hour ea.
Nov. 20	"Ethics"	6:30 pm	2 hours

Integris Baptist Medical Center: Donna Schoenfelder/Jean Middleton 405/949-3284

Nov. 2	"Advances In Electrical Treatment of Heart Failure"	7:00 am	1 hour
Nov. 3, 17	Tumor Board	7:00 am	1 hour
Nov. 8	"Genioplasty"– Vincent Montgomery, MD	7:00 am	1 hour
Nov. 10	Cancer Conference: TBA	7:00 am	1 hour
Nov. 10	"Treatment & Diagnosis of Low Back Pain & Lower Extremity Pain" @ The Waterford Hotel	8:00 am	6.5 hrs.
Nov. 13	"The Fifth Vital Sign"	7:00 am	1 hour
Nov. 17	OB/GYN Department	7:00 am	1 hour
Nov. 17	Ophthalmology Department	12:30 pm	1 hour
Nov. 20	"Human Genome Project"	12 noon	1.5 hrs.

Integris Southwest Medical Center: Jonathan Stotler 405/636-7087

Nov. 1	"Treating Hepatitis C"	12:15 pm	1 hour
Nov. 2, 9, 16, 30	Cancer Conference	12:15 pm	1 hour
Nov. 8	"Diabetes"	12:15 pm	1 hour
Nov. 15	"Compassion Fatigue"	12:15 pm	1 hour
Nov. 29	"Molecular Heparin & Hemostasis"	12:15 pm	1 hour

Mercy Health Center: Debbie Stanilla 405/752-3806

Nov. 2	"Hormone Replacement Therapy- The Balancing Act"	12:15 pm	1 hour
Nov. 7	Multidisciplinary Breast Conference: "Ductal Carcinoma"	7:00 am	1 hour
Nov. 9	"How to Manage Influenza with a Shortage Of Vaccines"	12:15 pm	1 hour
Nov. 15	Ethics For Lunch: Ethics and Aging	12 noon	1 hour
Nov. 30	"The Affliction: Domestic Violence"	12:15 pm	1 hour

St. Anthony Hospital: Sandy Coury 405/272-6358

Nov. 6	Grand Rounds: TBA		
Nov. 20	Grand Rounds: TBA		

St. John Medical Center: Gail Hilst 918/744-2875

Nov. 7	"Acute Meningitis"	12 noon	1 hour
Nov. 9	"Biochemical Markers of Myocardial Ischemia"	12 noon	1 hour
Nov. 14	ARDS (Acute Respiratory Distress Syndrome)	12 noon	1 hour
Nov. 16	SIADH	12 noon	1 hour
Nov. 21	"NeuroRadiology"	12 noon	1 hour
Nov. 28	"Acute Pancreatitis"	12 noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator, at 405/843-9571 or 800/522-9452.

Welcome to the New Millennium: AMA Foundation Celebrates 50 Years of Supporting Medical Education and Research

Pamela Robinson, OSMAA AMA Foundation Chair

This is the 50th year of the AMA Foundation. It is exciting to realize that, in that time, we have distributed $80 million in gifts to medical schools, guaranteed more than $96 million in loans for 40,000 medical students, and supported numerous research projects.

In 1950, the AMA recognized its responsibility to support medical education. They wanted to ensure that nothing compromised the quality of patient care and medical education in this country. For this reason the AMA Board of Trustees chartered the American Medical Education Foundation (AMA-EF), later called the AMA-ERF, and now known as the AMA Foundation, to receive and distribute funds for medical education. The Foundation's first meeting was held on February 14, 1951. Since the Foundation is a philanthropic arm of the AMA, the AMA covers all administrative costs. Every dollar collected by the Foundation goes to improving medical education or research.

In 1950, medical schools had a $10 million annual deficit, and many excellent students with great potential were turned away from the profession because of the high cost of fulfilling their medical dreams. Even my own father did not attempt a career in medicine because the general attitude in 1946 was that medical education was too expensive for most students. It takes a long time for excellent people to not be discouraged by the stigma of high cost.

Originally the AMA-EF distributed funds to medical schools through a collaborative effort with the National Fund for Medical Education (NFME), which was headed by former President Herbert Hoover. The AMA contributed $500,000 annually to the effort until 1955, when budgetary constraints forced it to be reduced to $100,000.

In 1956, the AMA called on its Auxiliary (now Alliance), to help increase contributions to the Foundation. For the past 45 years, state and local Alliances have promoted the goals of the AMA Foundation to physicians and their families, raising $72 million for medical education and student assistance. Due to the Alliance's efforts during the last five years, annual contributions from the medical family have averaged more than $2 million.

Even though the AMA Foundation had been around since 1951, I did not hear about it until 1979 when the Pottawatomie County Auxiliary asked me to be county Auxiliary President. Being new in town and pregnant, I hesitated . . . and hesitated. Finally someone said, "If you will do AMA-ERF I will be president. There is no work to being AMA-ERF Chairperson. We do not get many donations."

So I was off to my first state Board meeting to learn about four-layered forms, which are about as complicated as transcribing doctor's orders. To tell you the truth, I found that being AMA Foundation Chair is a lot of fun because Oklahoma physicians are generous and it is amazing and heart warming to see the large amounts that they invest in the future of medicine.

Next spring our state AMA Foundation will be auctioning donated items from across Oklahoma. Our many counties—large and small— will be working hard over the next five months to collect items for the auction. You will have a wonderful chance to buy these great items. Some will taste good and some will smell good; all will be pretty and great fun. Each county Alliance will put a great deal of creativity into its items. I hope you will come and be part of the fun. This wonderful event will occur during the OSMA/OSMAA Presidents' Inaugural Reception and Banquet, 6:00 pm, Friday, April 27, at the Cowboy Hall of Fame as part of the 2001 Annual Meeting.

Several local Alliances in Oklahoma sponsor sharing cards, which are a great way to make it through the holiday rush. Sharing cards give physicians and their spouses an opportunity to make a donation to the medical school or program of their choice. The holiday cards are sent to each member of the local medical community with the names of each donor. How much easier it is to write one check instead of addressing and stamping a card for each colleague!

Your Alliance will send Holiday wishes to your local AMA members and their families.

It is difficult in this busy world to have time to learn all the components of something as complicated as health care. So I want to thank you for reading this article!! And in closing, I ask you to not be left out—give generously to the future of medicine. If you would be interested in donating to the AMA Foundation, you can contact your county chairperson or Pamela Robinson by phone, 405/275-7410, or e-mail: pam7410@yahoo.com.

The Last Word

Assault Crime Bills Now In Effect

Two bills that establish penalties for individuals who commit assault on an emergency medical care provider or someone's assistive device took effect on Wednesday, November 1, 2000. HB 1885 by Representative Mike Wilt (R-Bartlesville) increases the maximum penalty for assaulting a medical-care provider who is performing medical-care duties from six months to one year in jail and from $500 to $1,000; the crime itself remains a misdemeanor. The bill also provides a description of "emergency medical care provider," which includes doctors, residents, interns, nurses, nurses' aides, ambulance attendants and operators, paramedics, emergency medical technicians, and members of a hospital security force. The other bill, HB 1902 by Representative Darrell Gilbert (D-Tulsa), creates a new category of crime for those who intentionally disturb someone's "assistive device." The bill defines this as any device that enables a person with a disability to communicate, see, hear, or maneuver; it reads in part, "Every person who, without justifiable or excusable cause and with intent to harass, touches any assistive device of another person, shall upon conviction, be guilty of a misdemeanor punishable by imprisonment in the county jail," for up to one year and a fine of $1,000, or both.

FTC Issues Consumer Alert on Lasik Eye Surgery

The Federal Trade Commission (FTC), together with the American Academy of Ophthalmology (AAO), have issued a consumer alert regarding Lasik eye surgery to correct refractive vision problems. The FTC cites an increasing number of complaints received regarding complications associated with the surgery and a lack of advertising disclosures about possible risks. A toll-free number, 877/FTC-HELP (877/382-4357) has been established for consumers to request a copy of the brochure, "Basik Lasik: Tips on Lasik Eye Surgery." The brochure, which is also available online at www.ftc.gov, discusses the risks and possible complications, how to decide if you're a candidate for the procedure, how to shop for a surgeon, and what to expect before, during, and after surgery. Alternatives to Lasik are also discussed, and resources for additional information are listed.

Recent Surveys Uncover Insurance Issues of Working Individuals, Small Businesses

Of America's 44 million uninsured individuals, 83% are employed by companies that do not offer health insurance as reported by a recent Employee Benefit Research Institute survey. The number of working uninsured has increased from 14.6% in 1987 to 18.1% in 1998. The survey also indicates that the working uninsured fall into certain segments of the population: in 1998, 53% of the working uninsured were under age 35; 58% were male; and 57% were white. Ninety percent of the working uninsured had college diplomas and 78% worked full-time.

According to the 2000 Small Employer Health Benefits Survey released by the Blue Cross Blue Shield Association, the Employer Benefit Research Institute, and the Consumer Health Education Council, small businesses do not provide health care coverage due to cost and lack of understanding of the tax laws, among other factors. The survey shows that nearly one-third of workers in firms with 25 or fewer employees are uninsured; lack of affordability was cited as the main reason why coverage wasn't offered by 53% of the employers surveyed. Employers also reported that more than one-third of their employees could not afford coverage. For more information on the surveys, visit www.ebri.org.

MEDLINE*plus* Undergoes Transformation

MEDLINE*plus*, the National Library of Medicine's consumer health information Web site, has undergone a transformation that provides a more user-friendly interface. Visitors to the site can now select from five categories of information: Health Topics, Drug Information, Dictionaries, Directories, and Other Resources. Keyword searches are also available. To visit the site, log on to www.nlm.nih.gov/medlineplus/.



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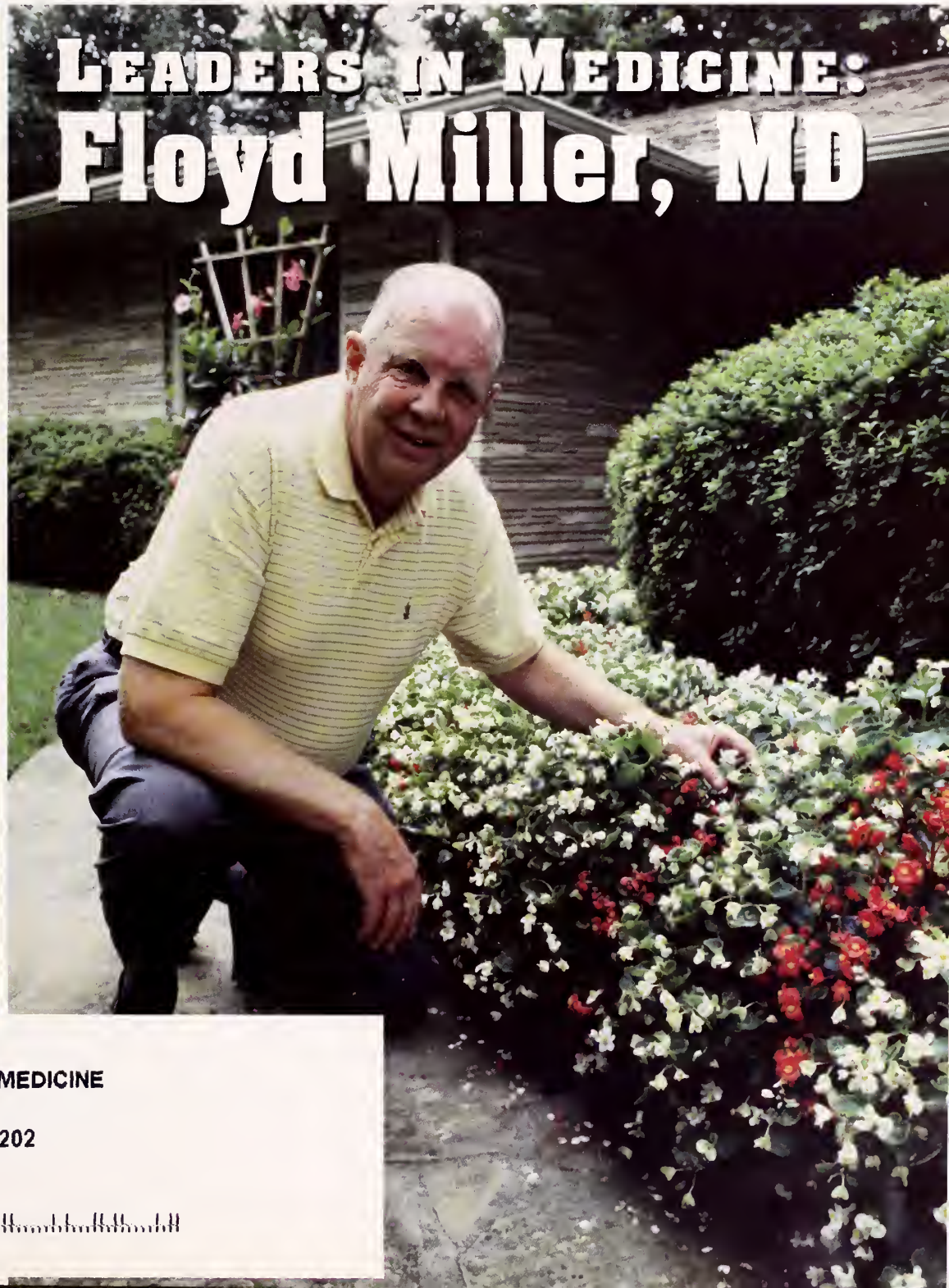
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me 93, Number 12

The Science and Art of Medicine in Oklahoma

JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION



LEADERS IN MEDICINE: Floyd Miller, MD

INSIDE:

The Oklahoma Repair Technique
551

Improving the Health of Oklahomans Through Clinical Prevention, Part III
557

News
580

2000 Index
581

--S12 P3 --4155
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DECEMBER 2000 VOL. 93, NO. 12

EDITORIAL

For Unto Us is Born 547
J. MICHAEL PONTIOUS, MD, ENID

PRESIDENT'S PAGE

A Call to Action 549
ROBERT J. WEEDN, MD, DUNCAN

SCIENTIFIC

The Oklahoma Repair Technique: A Biomechanical Study of a New Suture Repair Technique 551
HOUSHANG SERADGE, MD, OKLAHOMA CITY; WEN TIAN, MD, OKLAHOMA CITY; GHULAM H. KASHEF, MD, OKLAHOMA CITY; ALI SERADGE, OKLAHOMA CITY; WILLIS OWEN, PHD, OKLAHOMA CITY

SPECIAL

Improving the Health of Oklahomans Through Clinical Prevention, Part III: Immunizations and Chemoprophylaxis 557
JAMES M. CRUTCHER, MD, MPH, OKLAHOMA CITY; DAVID J. DEROSE, MD, MPH, SULPHUR; SARA REED DEPERSIO, MD, MPH, OKLAHOMA CITY

LEADER IN MEDICINE

Floyd Miller, MD 569
RICHARD GREEN, OKLAHOMA CITY

DOCTOR'S DIARY

Thoughts Upon Joy 578
HANNAH A. SAADAH, MD, OKLAHOMA CITY

NEWS

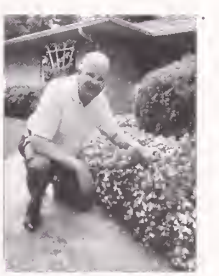
Polio Alert, 580...Ziegler Named to Cancer Liaison Program, 580...Vannatta Nominated for Humanism in Medicine Award, 580...AMA Interim Meeting Concludes, 580

DEPARTMENTS

Holiday Memories, 579...2000 Index, 581...In Memoriam, 589...Obituaries, 589...Alliance, 591...CME, 592...The Last Word, 596

ABOUT THE COVER

Floyd Miller, MD, is recognized as a Leader in Medicine. Photograph by Robert Taylor, Oklahoma City.



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**denotes Department Head*

For Unto Us is Born

It is Christmastime.

You will have to excuse my presumption and you will have to put up with my religious worldview. I do not mean to be disrespectful or narrow-sighted. Yes, I understand that there are other perspectives out there…but I have my belief set and it pervades my practice of medicine.

I practice medicine from the perspective of hope.



I understand that this perspective is becoming a bit out of vogue—you might even call it naïve. Yet it is woven into the very fabric of my medical care. It is such a strong part of the tradition of our profession that I can see no way around incorporating hope into the everyday, the mundane, and the routine.

Yet hope is anything but routine.

With our science, with our advancing understanding and sophistication, we seem to have placed this matter of hope into the back seat. It has been relegated to those tools that we euphemistically call "feely-touchy," only brought out of our toolbox when all else has failed.

Is that really where the "medical" use of hope belongs?

I am reminded of a birth many years ago. I had recently taken this faculty position, still trying to make the transition from the rural family doctor that I have always envisioned myself as being to the "all-knowing, unflappable attending physician." The phone rang at three o'clock in the morning, awaking me from a sound sleep. On the other end was a frantic labor and delivery nurse telling me that the resident had a breach delivery in which the aftercoming head had gotten trapped.

That four-minute dash to the hospital seemed to go on forever.

As I turned the corner to the labor suite, the resident was pale; the infant torso in his hands was a dark purple and appeared extremely small. With maneuvers that I cannot recall to this day, this child was delivered…all one pound, six ounces of him. Not breathing spontaneously and with thready pulse, the resident and I went to work at our resuscitation attempt. Intubation followed, as did a better heart beat and blood pressure.

Yet the child did not respond to stimulation. Had we resuscitated a child that would never understand or enjoy a Christmas morning?

Each moment brought me closer to abandoning that precious component of medical care…hope.

The helicopter was summoned, the crew came and whisked this child away to Children's NICU. I must admit that I breathed a bit deeper once this had occurred. And soon I forgot about that child, distracted by the myriad other responsibilities that were put in my path. Months and years passed. I would often pause to wonder what happened to that child. Christmastime always seemed to remind me to think of this child even as I enjoyed watching my own children.

It always took me back to that moment, seeing those purple buttocks and that small torso suspended there—trapped.

Years later I am reading my e-mail, which is a daily chore for me. I had posted a message to an academic list on some point that I wanted to make for the group. I was reviewing the comments that other members of the list were giving to my post. I opened an e-mail from a medical student in Chicago. He asked me if I would be willing to see his girlfriend's relative who lived in Enid. They were having troubles getting in to see a physician. He had seen my e-mail and put the Enid, Oklahoma address together with the need of his girlfriend's family. I e-mailed back the office number and told him how to make the appointment.

I walk into the exam room to see this patient…a child. This child…for whom I had come so close to abandoning all hope.

This child is currently a straight-A student in the third grade. He is kind, compassionate, and loved by all who know him. I really don't think he understands fully this concept of hope, but one day I am confident he will learn how he renewed the spirit of this aging, cynical physician who just needed a good strong dose of displayed hope…



J. Michael Pontious, MD
Editor-in-Chief

"With our science, with our advancing understanding and sophistication, we seem to have placed this matter of hope into the back seat. It has been relegated to those tools that we euphemistically call 'feely-touchy,' only brought out of our toolbox when all else has failed."

An editorial is a column of personal opinion that may or may not reflect the official position of the OSMA.

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President's Page

A Call to Action

Mark your calendar now for Medicine Day at the Capitol, Wednesday, February 21, 2001, and plan to join the OSMA and OSMA Alliance leadership for the afternoon to meet with our state's leaders in a show of physician interest and force in the legislative process. Make no mistake—this is a call to action. We must show the legislature and the people of Oklahoma that physicians are intensely interested in and want our voices to be heard on the issues that will be brought before the 48th session of the Oklahoma legislature. The 2001 OSMA legislative agenda, the elements of which will affect you, your practice, your patients, and your profession, is tentatively outlined as follows:



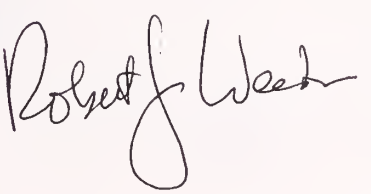
1. Monitor the development of legislation to implement State Question 692, the Tobacco Settlement Trust Fund.
2. Support increases in funding for the state Medicaid program.
3. Overturn workers' compensation fee and treatment schedule reductions of 7.5%.
4. Introduce legislation defining clean claims, creating uniform prompt pay provisions under the various statutes governing third-party payments, and strengthening enforcement of prompt pay provisions.
5. Introduce legislation that develops a process whereby unused non-narcotic prescription drugs may be transferred from nursing homes to the medically indigent.
6. Introduce legislation requiring the Oklahoma Health Care Authority to extend coverage from six months to twelve months for health care services to eligible Medicaid recipients.
7. Introduce legislation requiring the Oklahoma Health Care Authority to require HMOs providing services to Medicaid recipients to pass through funding increases to providers.

In addition to the legislation introduced by the OSMA, other legislative issues of importance to physicians and the practice of medicine will be closely monitored for their potential impact on our members, and will be responded to accordingly.

The format for Medicine Day 2001 will be different from years' past; we hope this schedule will be more convenient for physicians, their spouses, and office staff to participate. Registration will begin at 2:30 pm in the Blue Room on the second floor of the Capitol. We will begin with brief remarks from Oklahoma's top legislative leaders, followed by time for physicians to meet with their individual legislators. During your visits with your legislators, invite them to attend a complimentary reception at the Clarion Hotel beginning at 5:00 pm. Registration forms for the day's events will be sent to all OSMA and OSMA Alliance members prior to Medicine Day.

Physicians, their spouses, and office staff are encouraged to attend to help us reach our goal of 2001 people at the Capitol on Medicine Day 2001. Mark your calendar now to make a difference. This once-a-year opportunity joins the voices of physicians from across the state in a unified show of support for medicine in Oklahoma. And if not now, when?

Best wishes to you, your families, and staff for a glorious holiday season and a wonderful and happy New Year.



Robert J. Weedn, MD
OSMA President

"This once-a-year opportunity joins the voices of physicians from across the state in a unified show of support for medicine in Oklahoma."

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The Oklahoma Repair Technique: A Biomechanical Study of a New Suture Repair Technique

Houshang Seradge, MD; Wen Tian, MD; Ghulam H. Kashef, MD; Ali Seradge; Willis Owen, PhD

We designed and evaluated the biomechanical advantages of a new (Oklahoma) suture technique for repairing flexor tendons in fresh, frozen cadaver specimens. Forty flexor digitorum profundi tendons from the middle three fingers were sharply cut and repaired with a number 3-0 braided polyester using the new technique and the Modified Kessler technique with and without an epitenon repair. The repaired tendons were then stressed to failure. The Modified Kessler with epitendon repair initiated gap formation on an average of 15.3 ± 2.7 newtons and failed at 40.9 ± 4.3 newtons. The Oklahoma suture technique with a running epitenon repair initiated gap formation on average of 48.6 (SD ± 4.0) newtons and required an average load of 57.9 (SD ± 3.0) newtons to fail. Thus, it was significantly stronger than the modified Kessler technique with epitendon repair ($P<0.01$). The tendons repaired with the Oklahoma and epitenon repair suture technique did not form a 2 mm gap prior to failure. The epitendon repair increased the resistance to gap formation by 80% to 100% and the repair failure by 17.5% to 25% for both types of repairs. We concluded that the addition of the epitendon repair increases the tensile strength of the repair regardless of the core suture technique, and it should be used. In comparison with the Modified Kessler repair technique, the Oklahoma repair technique has superior tolerance to gap initiation, 2 mm gap formation, and physical failure of the repaired tendon.

Introduction

Repair of lacerated flexor tendons in the hand gained acceptance after Avicina (980-1037 A.D.), a Persian master surgeon, recommended it in the 10th century.[1] The goal of such a repair is to return normal function to the hand. To achieve finger flexion, the tendon should have continuity and to glide smoothly to transfer the muscle force to the fingertip. However, this goal was difficult to achieve due to immobilization of the hand after a flexor tendon repair. While immobilization appeared to decrease the chance of rupturing the repaired tendon, it assured a secondary surgical procedure to release adhesions. Early mobilization of the flexor tendon was later documented to have a beneficial effect in reducing the adhesion formation and improving tendon gliding.[2,3] The passive flexion and active extension protocol[4-6] provided meaningful and reproducible postoperative care. Further investigation proved that early postoperative active motion of a flexor tendon is associated with decreased scar formation, faster healing time, and a stronger healed tendon.[3] However, early active range of motion after a flexor tendon repair requires a strong repair. The strength of the repair site depends on the tensile strength of the suture material, tensile strength of suture configuration, and the "grasping" capability of the suture technique to disallow the physical failure of repair by suture pull out or suture breakage. Furthermore, Seradge[7] introduced the concept of functional failure of a flexor tendon repair. Through his in vivo studies, he documented that gap formation of more than 2 mm at the suture line was associated with a high percentage of functional failure of the repaired

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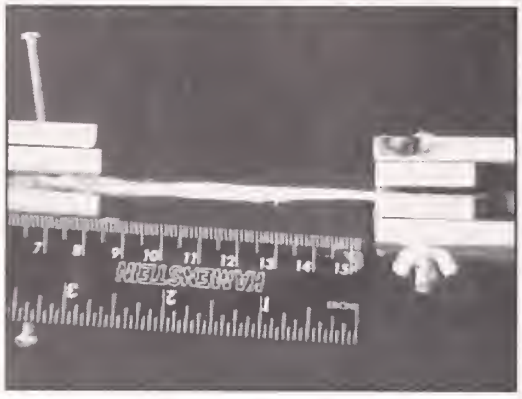


Figure 1. Repaired lacerated fresh frozen flexor digitorum profundus tendon pre-loaded in the MTS-80 machine.

flexor tendon. Therefore, a stronger suture material and a repair technique more resistant to gap formation than the present techniques is desirable.

We designed and named a new weave technique—the Oklahoma repair technique. We performed a series of studies on human fresh frozen flexor digitorum profundus tendons using the new weave technique. The commonly used modified Kessler technique was chosen for our control group.

Materials

Forty flexor digitorum profundi tendons of the index, long, and ring fingers were harvested from cadavers frozen within 24 hours after death. Each tendon remained attached to the distal phalanx. The length of the harvested tendon measured from the distal interphalangeal level was 12 cm. The tendon was cut sharply 4 cm from the proximal end of its distal phalanx perpendicular to the long axis of the tendon. The tendon was then randomly assigned to one of the two study groups. The cut tendon was repaired according to the protocol and the strength of the repair was tested. We investigated the tension necessary to initiate a gap, to create a 2 mm gap, and to achieve physical failure of the repair. The failure mode was observed and documented on a high-speed digital video recorder.

We used a Number 3-0 braided polyester suture material for the modified Kessler and the double interlock suture technique. A Number 6-0 monofilament nylon simple-running suture technique[8] was used for the epitenon suture.

Study Design

Test Groups

We studied four groups of flexor tendon repairs: Group I, flexor tendons repaired using a modified Kessler technique[9,10] without an epitenon repair; Group II, flexor tendons repaired using a modified Kessler technique with an epitenon repair; Group III, flexor tendons repaired using the Oklahoma repair technique without an epitenon repair; and Group IV, flexor tendons repaired using the Oklahoma repair technique with an epitenon repair.

Testing Machine

We used a Material Testing System machine MTS-810 (MTS System Corp; MpLS, MN) to apply tension to the repair site. The data was collected by a computer, and graphs were drawn by an electronic plotter.

Testing Mode

All specimens were loaded into two sandpaper crosshead clamps of the MTS machine (Figure 1). The repaired tendon was pre-loaded to 5 newtons. The strain rate of the cross-head was 20 mm/min and constant for all specimens. We continued loading the tendon until physical failure of the repair occurred.

Visual Recording

We recorded each experiment digitally from the time of preload to complete physical failure of the repair. We used a DV digital tape and a Sony digital DCR VX-1000 recorder. The recorder was placed at a constant distance of 150 cm from the tendon, and its viewing axis was perpendicular to the long axis of the loaded tendon in the MTS machine. The lapsed time was burned onto the videotape by the recorder's chronograph.

Synchronicity

The video camera and the MTS machine were connected to a single electric switch to assure synchronicity of the recorded time in the machine and the video camera.

Gap Initiation and 2 mm Gap Formation

In order to measure the initiation of gap formation and the time elapsed until a 2 mm gap was created, we mounted a ruler parallel to the tendon to the upper clamp of the crosshead clamps of the MTS machine (Figure 1). We defined the exact time of each incidence on videotape and noted the time when the gap physically initiated and when it reached the 2 mm limit. We then

measured the applied tension by the corresponding time-strain plot.

Physical Failure Types

The tendons were loaded to physical failure that occurred by either suture pull out or suture material breakage. The type of failure was documented by the high-speed digital recorder.

Time of Testing

All specimens were tested within eight hours of thawing. All tendon specimens were kept moist with ringer solution before and after the cut, during the repair, and during the experiment.

The Modified Kessler Suture Technique

We used one 3.0 polyester suture strand for repair with the locks placed 2 cm from the edge of the tendon. The knot was placed intratendinous[9] (Figure 2).

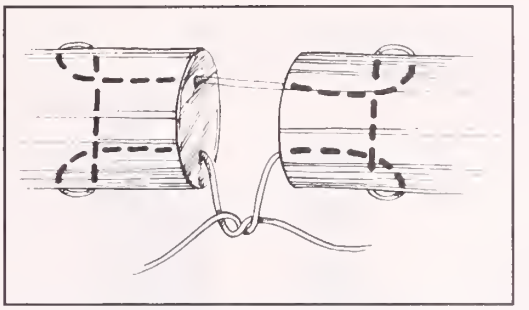


Figure 2. The modified Kessler repair technique

The Modified Kessler and Epitenon Suture Technique

We used the same core suture as was used for the Modified Kessler suture technique. The repair was complemented by a simple running suture technique using a single strand of Number 6-0 nylon.[10] The bite was 1 cm from the cut end of the tendon.

The Oklahoma Suture Technique

We used a double-ended 3.0 polyester suture. We started the repair 2 cm away from the cut edge of the tendon. We passed the suture through the tendon perpendicular to the tendon's long axis until equal length suture was achieved on either side of the tendon. The suture on the left side of the tendon was returned by passing through the tendon 0.3 mm to 0.5 mm closer to the cut edge of the tendon, creating loop "a" (Figure 3a). Then, the suture on the right side of the tendon was returned creating loop "b." The left suture was then passed through loop "b" and returned through the ring created by its exit from the tendon, locking itself when tension was placed on it. The right suture was passed through loop "a" with the same manner discussed above. The right and left sutures were then pulled until loops "a" and "b" were flushed with the tendon and the locks were snug. This process was repeated one more time creating two interlocks on one side of the tendon (Figure 3b). The sutures were then passed intra-tendinously to the opposite end of the lacerated tendon. The first interlock was created 0.5 cm from the laceration (Figure 3c). The tension on this interlocking suture defines the repair site approximation. This is an important step as the sutures are locking in nature, and readjustment after the second set of passes will not be possible unless the interlocks are undone. The second interlock was created and the suture strands were then tied in a knot outside of the tendon. The end result was two interlocking passes on each side of the lacerated tendon.

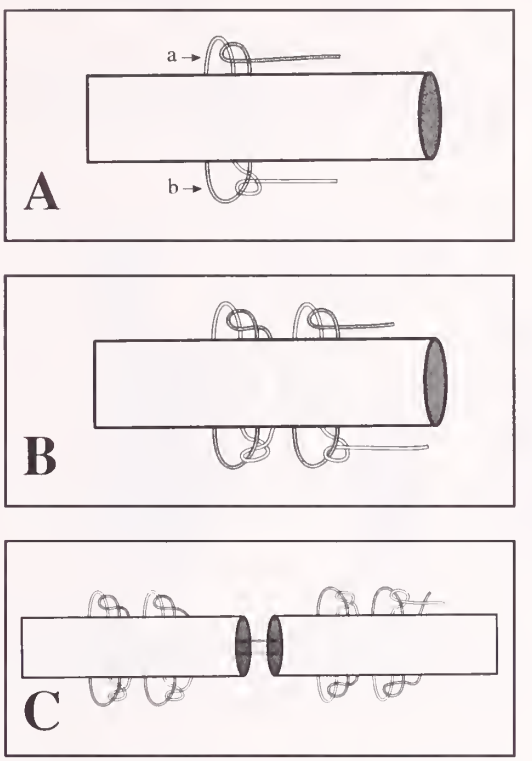


Figure 3. The Oklahoma flexor tendon repair technique. Figure 3a. Each arm of the suture will loop inside the opposite suture return loop, creating a locking pass. The return loops are indicated "a" and "b." Figure 3b. The configuration is repeated and the double loop completed on one side. Figure 3c. The core suture is passed intratendinously to the opposite site and two lock complexes are formed. The suture is tied outside of the tendon.

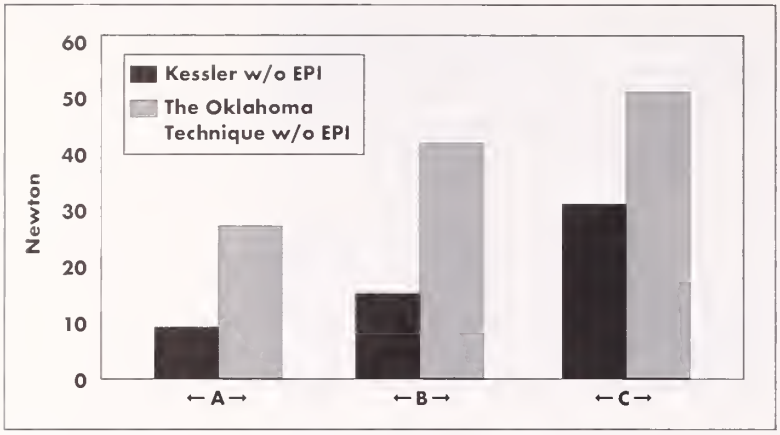


Table 1. Comparison of a modified Kessler without epitendon suture technique to the Oklahoma repair without epitendon suture techniques. The tendons are loaded to gap initiation (A), 2 mm gap formation (B), and repair failure (C).

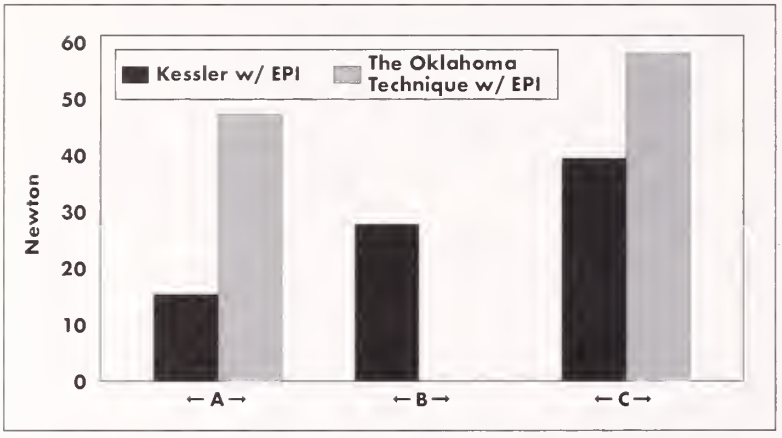


Table 2. Comparison of a modified Kessler with epitenon suture technique to the Oklahoma repair with epitenon suture techniques. The tendons are loaded to gap initiation (A), 2 mm gap formation (B), and repair failure (C).

The Oklahoma Suture with Epitendon Repair

We used the core suture used in the Oklahoma suture technique; this repair was complemented by a peripheral repair using the Modified Kessler and epitendon suture technique.

Statistical Analysis Method

Analysis of variance is a statistical method in which the total variation observed in a set of data is partitioned into additive parts. Each part estimates the portion of the total variation attributable to either a "main effect," an "interaction," or to "error." If there are no significant interaction effects, then the main effect gives a test of the equality of the means in the populations determined by the levels of the main effect. If there are significant interaction effects, then the main effects cannot be interpreted directly, and simple effect analysis must be done.

The design of this study is a $2 \times 2 \times 3$ completely randomized design. The distributions of the variables of interest were examined in each of the 12 treatment combinations. Based on this examination, it was concluded that the assumption necessary for an analysis of variance was met. For each of the three response variables, a $2 \times 2 \times 3$ analysis of variance was done. For all three variables, interaction effects were observed, so simple effect analyses were performed. The analysis was done using the GLM (General Linear Models) procedure in the SAS statistical package. The GLM procedure constructs the analysis of variance by using indicator variables in a regression model. This method is applicable to all situations; however, it provides an elegant method of analysis when the treatment combinations do not have the same number of observations.[11,12]

Results

Group I

Ten flexor tendons were repaired using the modified Kessler suture technique without an epitenon repair. The gap formation was initiated at the average tension of 8.4 (SD ± 1.1) neutons. The 2 mm gap in the flexor tendon repairs occurred at the average tension of 15.3 (SD ± 2.4) neutons. The flexor tendon repairs failed at the average applied tension of 33.4 (SD ± 4.5) neutons (Table 1). Suture pull out from the tendon substance, not breaking of the suture material, was the mode of failure for all the flexor tendons repaired in this group.

Group II

Ten flexor tendons were repaired using the modified Kessler with an epitenon suture technique. The gap formation was initiated at the average tension of 15.3 (SD ± 2.7) neutons. The 2 mm gap in the flexor tendon repair occurred at the average tension of 27.8 (SD ± 3.0) neutons. The flexor tendon repairs failed at the average applied tension of 40.9 (SD ± 4.3) neutons (Table 2). Suture pull out from the tendon substance was the mode of failure in all but three of the flexor tendons repaired in this group. The suture material broke in three repairs.

Group III

Ten flexor tendons were repaired using the Oklahoma suture technique without an epitenon suture. The gap formation was initiated at the average tension of 28.8 (SD ± 2.4) neutons. The 2 mm gap in the flexor tendon repairs occurred

at the average tension of 40.5 (SD ± 2.7) neutons. The flexor tendon repairs failed at the average applied tension of 46.9 (SD ± 3.1) neutons (Table 1). Failure of the suture material was the mode of failure in all the flexor tendons repaired in this group. All sutures broke at first interlock. Suture pull out was not the cause of repair failure for any tendons in this group.

Group IV

Ten flexor tendons were repaired using the Oklahoma suture technique with an epitenon suture technique. The gap formation was initiated at the average tension of 48.6 (SD ± 4.0) neutons. The 2 mm gap in the flexor tendon repairs was not observed in this group until the physical failure of the repair. The flexor tendon repairs failed at the average applied tension of 57.9 (SD ± 3.0) neutons (Table 2). Suture pull out was not observed, and failure of the suture material was the mode of failure in all the flexor tendons repaired in this group. All sutures broke at the first interlock.

Table 3. Biomechanical results of the tested repair techniques in the MTS-80 machine.

Suture size #3-0	Kessler		The Oklahoma Technique	
	w/o EPI	w/ EPI	w/o EPI	w/ EPI
Load at gap initiation (N)	8.4 ± 1.1	15.3 ± 2.7	28.8 ± 2.4	48.6 ± 4.0
Load at 2mm gap (N)	15.3 ± 2.4	27.8 ±3.0	40.5 ± 2.7	– –
Load at Failure (N)	33.4 ± 4.5	40.9 ± 4.3	46.9 ± 3.1	57.9 ± 3.0
Failure made	P=10	P=7 / K=3	F=10	F=10

P = failure by suture pull out (cut out) through the tendon. F = failure by the suture breakage at the first loop or knot. w/Epi = with epitenon repair. w/o Epi = without epitenon repair.

Discussion

It is widely accepted that the ideal regimen to use after a flexor tendon repair is immediate active motion of the fingers.[13] However, the tensile strength of the existing flexor tendon repair techniques does not meet the required strength to allow initiation of early active motion safely. Therefore, the search for a better repair technique and stronger suture material should continue. A tensile strength of over 1,000 grams is required to withstand the tension necessary to achieve an unresisted active digital flexion.[14] Also, we know that the tensile strength of the repair decreases up to 60% in the second week after flexor tendon repair.[15] Therefore, a flexor tendon repair should have a minimum tensile strength of 2,500 grams at the repair site to allow a safe non-resisted active range of motion program immediately after the repair.[14]

The "holding" or "grasping" capability of a suture configuration is an important factor in the success of a repair. If the tendon repair fails due to suture pull out, the "holding" or "grasping" quality of the repair configuration is insufficient. Furthermore, when the "grasping" or "holding" quality of the suture configuration is not sufficient, the repair will give under sub-failure level of tension and will cause a gap formation between the tendon ends. The gap formation causes a functional failure of flexor tendon repair.[7]

We studied the Oklahoma repair technique with and without epitendon repair and compared them to the standard modified Kessler repair technique. The Oklahoma repair without an epitenon repair started gapping at an average 28.8 (± 2.4) neutons. This was significantly stronger than the modified Kessler with the same caliber suture. When the epitendon suture was added to the repair, the Oklahoma suture technique required an average of 48.6 ± 4.0 neutons to start a gap formation, compared to 15.3 ± 2.7 neutons for the modified Kessler technique ($P<.01$). A 2 mm gap formation was observed in the modified Kessler without an epitendon repair at an average of 15.3 ± 2.4 neutons, and in the modified Kessler with an epitendon repair at 27.8 ± 3.0 neutons. The 2 mm gap was observed in the Oklahoma repair without an epitendon repair at an average of 40 ± 2.7 neutons. The 2 mm gap was not observed in any of the tendons repaired using the Oklahoma technique with the epitendon repair technique. In other words, the gap was initiated but the grasp or holding capacity of the repair was strong enough that the repair failed due to the suture breaking before the gap could reach 2 mm.

We also studied the method in which a flexor tendon repair failed. Tendons repaired with the modified Kessler repair technique without an epitendon repair all failed by suture pull out. When an epitendon repair was added, 70% failed by suture pull out, and 30% failed by suture material failure. Tendons repaired with the Oklahoma technique with or without epitendon repair did not experience suture pull out, but failed by suture material failure only (Table 3). This observation further confirmed the superior "grasping" quality of the Oklahoma suture configuration.

We analyzed the tensile force required to produce a 2 mm gap and the tensile force required to cause suture failure. We found the additional force required to cause physical failure of the repair from 2 mm gap formation decreased when the Oklahoma technique with epitendon was used (Table 3). This finding fur-

ther confirmed superiority of the Oklahoma technique in grasping the tendon.

Addition of epitenon repair adds to the tensile strength of the core suture significantly, regardless of the repair technique. Its contribution to the tensile strength was considerably higher when the core repair was weaker. Also, addition of the epitendon suture increases the resistance to gap formation by 80% to 100% (Table 3) and increases the tensile strength at mechanical failure by 17.5% to 25%. Therefore, we recommend using an epitenon repair regardless of the core suture technique chosen.

Tendon vascularity is always a concern when considering which repair techniques to use. During flexor tendon repair procedures, it is often observed that the side of the lacerated tendon further away from the vincula does not bleed. Furthermore, it is well documented that flexor tendons heal well even without vascular supply.[16-17] Yet, the surgeon may wonder if the possibility of compromising an already inadequate circulation should be enough to forego the benefits of a strong repair technique. We can safely assume that the blood supply to the tendon, if there is any meaningful supply present, will be compromised to some extent by using the double interlock repair technique. However, we gain an impressive 16.98 ± 4.91 neutons in repair strength ($P<0.01$).

The Oklahoma suture technique can be a useful tool for the repair of flexor tendons. It has a superior holding power for resisting gap formation; with the addition of an epitendon repair, a 2 mm gap does not occur. Therefore, the chance of functional failure of the repair due to gap formation is eliminated. The Oklahoma repair configuration is more tolerant to tension. The suture pull out was not observed and the physical failure occurs only because of suture material failure.

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Improving the Health of Oklahomans Through Clinical Prevention, Part III: Immunizations and Chemoprophylaxis

James M. Crutcher MD, MPH; David J. DeRose MD, MPH; Sara Reed DePersio MD, MPH

Vaccines are one of the greatest achievements of biomedical science and public health and are clearly one of the most effective tools of clinical prevention. Diseases that once caused significant morbidity and mortality in Americans—particularly children—have been virtually eliminated from the population through effective immunization programs. But until these diseases have been eradicated globally we must continue to maintain high immunization levels to prevent their return; a 90% coverage rate has been set as the national goal for recommended vaccines in preschool-age children. In Oklahoma we have only achieved that goal for two vaccines (measles and polio) and for the last several years we have ranked near the bottom in vaccine coverage rates compared to other states. Although achieving high vaccination rates in children involves numerous partners, private physicians must play a major role in that effort since they are the primary vaccine providers in the state. Physicians should also be alert to the vaccine needs of their adolescent and adult patients, particularly for pneumococcal disease, influenza, hepatitis A and B, and tetanus. This article describes current vaccination levels in Oklahoma children and adults for several routine and newly recommended vaccines and discusses the role of private physicians in maintaining and improving immunization coverage.

Introduction

This is the final article in a three-part series that explores the role of clinical prevention in improving the health status of Oklahoma citizens. As documented in the *State of the State's Health Report*,[1] Oklahomans suffer higher levels of morbidity and mortality from several common conditions—coronary heart disease, chronic lung disease, stroke, and injury—than the residents of most other states. These articles are based upon the premise that our best hope for decreasing the impact of these conditions lies with various prevention-oriented interventions, and that practicing clinicians play a substantial role in that effort. Our goal has been to make Oklahoma clinicians aware of research-proven, effective clinical preventive interventions and the current recommendations for the use of those interventions in clinical settings. We believe that the effective use of preventive services by thousands of clinicians across the state can decrease the statewide impact of our most common health problems, while at the same time improving the health of individual patients.

Clinical prevention refers to preventive services provided by physicians or staff in their offices during routine patient care and can be categorized into three general types of services: a) counseling to modify high-risk behaviors; b) screening to identify early-stage disease and disease risk factors; and c) immunizations and chemoprophylaxis to prevent common infectious diseases. Parts I and II of this series addressed counseling[2] and screening,[3] respectively; in this article we discuss immunization and chemoprophylaxis. The recommendations made here are based primarily upon the findings of the US Preventive Services Task Force (USPSTF). The task of that body was to thoroughly review current preventive medicine research and make recommendations as to which office-based interventions have been clearly shown to decrease morbidity and mortality in asymptomatic Americans. The USPSTF

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Table 1. Age-Specific Immunization and Chemoprophylaxis Recommendations of the US Preventive Services Task Force and the Advisory Committee for Immunization Practices

Birth to 10 Years

Immunizations

- Diptherio-tetonus-ocellulor pertussis (DToP) — 2, 4, 6, 15-18 mo, ond 4-6 yr.
- Inoctivoted poliovirus (IPV) — 2, 4, 6-18 mo, ond 4-6 yr.
- Meosles-mumps-rubello (MMR) — 12-15 mo, 4-6 yr.
- Hoemophilus influenzo type b (Hib) conjugote — 2, 4, 6, ond 12-15 mo. No dose needed at 6 mo if PRP-OMP voccine used for first 2 doses.
- Hepotitis B — birth, 1 mo, 6 mo; or 0-2 mo, 1-2 mo loter, ond 6-18 mo. If not done in infoncy: current visit ond 1 ond 6 mo loter.
- Voricello — immunocompetont infonts 12-18 months or older, without history of chickenpox or previous immunizotion. Include informotion on risk in odulthood, durotion of immunity, ond potentiol need for booster doses.
- Pneumococcol polysocchoride-protein conjugote — 2, 4, 6, ond 12-15 mo.

Chemoprophyloxis

- Birth — Oculor Prophyloxis

Ages 11 to 24 Years

Immunizotions

- Tetonus-Diptherio (Td) boosters (11-16 yr).
- Hepotitis B — if not previously immunized: current visit, 1 ond 6 mo loter.
- MMR (11-12 yr) — If no previous, second dose of MMR.
- Voricello (11-12 yr) — If immunocompetent ond susceptible to chickenpox.
- Rubello (femoles>12 yr) — Serologic testing, documented voccinotion history, ond routine voccinotion (preferobly with MMR) ore equolly occeptoble olternotives.

Chemoprophyloxis

- Multivitomin with folic ocid (femoles plonning/copoble of pregnoncy)

Ages 25 to 64 Years

Immunizotions

- Tetonus-diptherio (Td) boosters.
- Rubello (women of childbeoring oge) — Serologic testing, documented voccinotion history, ond routine voccinotion (preferobly with MMR) ore equolly occeptoble olternotives.

Chemoprophylaxis

- Multivitomin with folic ocid (women plonning or copoble of pregnoncy).
- Discuss hormone prophyloxis (perimenopousol ond postmenopousol women).

Ages 65 and Older

Immunizotions

- Pneumococcol voccine.
- Influenzo voccine — Annuolly.
- Tetonus-diphtherio (Td) boosters.

Chemoprophyloxis

- Discuss hormone prophyloxis (femoles).

findings were published in *The Guide to Clinical Preventive Services*,[4] and later used as the scientific background for the "Put Prevention in Practice" program and its companion book, *The Clinician's Handbook of Preventive Services*.[5] The complete list of USPSTF recommendations for immunizations and chemoprophylaxis is shown in Table 1.

The Impact of Immunizations

When one thinks of great public health triumphs, immunizations surely stand at the top of the list. Prior to the availability of vaccines, infectious diseases were widely prevalent in the United States and exacted an enormous toll on the population. For example, in 1900, 21,064 smallpox cases were reported and 894 patients died. In 1920, 469,924 measles cases were reported and 7,575 patients died; 147,991 diphtheria cases were reported and 13,170 patients died. In 1922, 107,473 pertussis cases were reported and 5,099 patients died.[6] In the mid-1900s, polio caused approximately 16,000 paralytic cases per year. Following successful immunization programs, dramatic declines occurred for these diseases and other common childhood infections. Smallpox has been eradicated globally and polio from the Western Hemisphere (and efforts are underway for global eradication). Morbidity associated with several other vaccine-preventable diseases has been reduced by 95% to 100% (Table 2). Similarly in Oklahoma, most of the childhood vaccine-preventable diseases have been virtually eliminated. Cases of vaccine-preventable diseases reported in Oklahoma in 1998 were: pertussis, 34; mumps, 5; *Haemophilus influenzae* type b (Hib) < 5 years old, 1; and no cases of measles, polio, rubella, diphtheria, or tetanus.

Childhood vaccinations are, in general, also very cost-effective. For measles-mumps-rubella vaccine (MMR), an estimated $16.34 in savings from medical costs results from every dollar spent on vaccine. Significant savings also result from the use of diphtheria/tetanus/pertussis (DTP) and chickenpox vaccines, with estimated savings of $6.21 and $5.40 for each dollar spent, respectively.[7]

Current Vaccination Coverage Among Children

The prevention of childhood infectious diseases requires sustained high vaccination levels in the population. Laws that mandate vaccination for school entry provide the best mechanism for assuring high vaccination levels in school-age children. Obtaining high vaccination levels in younger children—those who are at highest risk for many of the vaccine-preventable diseases—is more difficult and requires more intensive efforts. In an effort to increase vaccination levels in children aged 19 to 35 months, the Childhood Immunization Initiative was launched in 1993 and set ≥ 90% coverage goals for recommended vaccines. The National Immunization Survey (NIS), an ongoing telephone survey that gathers data about vaccina-

Table 2. The Impact of Vaccines in the United States During the 20th Century[6]

Disease	Baseline 20th Century Morbidity (prior to vaccination availability)	1998 Provisional Morbidity	Percent Decrease*
Smallpox	48,164	0	100%
Paralytic Paliamyelitis	16,316	0	100%
Diphtheria	175,885	1	100%
Measles	503,282	89	100%
Haemaphilus influenzae type b	20,000	54	99.7%
Mumps	152,209	606	99.6%
Rubella	47,745	345	99.3%
Cangenital Rubella Syndrame	823	5	99.4%
Tetanus	1,314	34	97.4%
Pertussis	147,271	6,279	95.7%

* rounded to the neorest tenth

Table 3. Estimated Vaccination Coverage with Selected Vaccines and Combined Series Among Children Aged 19 to 35 Months, Oklahoma vs US Average, National Immunization Survey, 1998[8]

Vaccine	Oklahoma % (95% CI)	National Average % (95% CI)
DTP[a]	79.7 (± 6.0)	83.9 (± 0.8)
Palia[b]	93.5 (± 3.8)	90.8 (± 0.7)
MCV[c]	94.1 (± 3.5)	92.1 (± 0.6)
Hib[d]	88.7 (± 5.1)	93.4 (± 0.6)
Hep B[e]	85.4 (± 2.2)	87.0 (± 0.7)
Varicella[f]	49.5 (± 7.0)	43.2 (± 1.0)
4:3:1[g]	78.5 (± 6.1)	80.6 (± 0.9)
4:3:1:3[h]	75.3 (± 6.4)	79.2 (± 0.9)

a Four or more doses of ony diphtheria ond tetonus toxoids ond pertussis vaccine (DTP) (i.e diphtherio ond tetonus toxoids ond pertussis vaccine, diphtherio ond tetonus toxoids (DT), or diphtherio ond tetonus toxoids ond ocellulor pertussis vaccine (DtoP)).
b Three or more doses of poliovirus vaccine (Polio).
c One or more doses of meosles-contoining voccine (MCV).
d Three or more doses of Hoemophilus influenzoe type b voccine (Hib).
e Three or more doses of hepotitis B voccine (Hep B).
f One or more doses of voricello voccine.
g Four or more doses of DTP, three or more doses of Polio, ond one or more doses of MCV.
h Four or more doses of DTP, three or more doses of Polio, one or more doses of MCV, ond three or more doses of Hib.

tion coverage for children aged 19 to 35 months in each of the 50 states and 28 urban areas, is the primary source of vaccination coverage data in the United States.

Data from the 1998 NIS indicate that national immunization levels for the routinely recommended childhood vaccines are at the highest levels ever reported, but that substantial variation in coverage exists between different state and urban areas. Vaccination coverage with three doses of polio vaccine, three doses of Hib vaccine, and one dose of measles-containing vaccine (MCV) was greater than 90% each, and coverage with four doses of any diphtheria/tetanus/pertussis vaccine (DTP) and three doses of hepatitis B vaccine was the highest ever reported (83.9% and 87%, respectively). Coverage with varicella was also the highest ever reported (43.2%).[8]

In 1998, Oklahoma achieved 90% coverage levels for only two vaccines—polio and MCV. For most of the other vaccines we fall below the national average (Table 3). In particular, we rank poorly in our "4:3:1" comparison to other states (4 doses of DTP, 3 doses of polio, and 1 dose of MCV). The "4:3:1" series of vaccines is used as a sentinel indicator of how well states are achieving complete immunization with the primary vaccines. Over the last several years, Oklahoma has consistently ranked near the bottom in "4:3:1" coverage compared to other states, primarily due to failure to deliver the fourth DTP dose at 12 to 18 months of age.

Table 4. Conditions that are NOT Contraindications to Vaccination

- Mild to moderote locol reoction (soreness, redness, swelling) following o dose of on injectoble ontigen.
- Mild ocute illness with or without low-grode fever.
- Current ontimicrobiol theropy.
- Convalescent phase of illnesses.
- Premoturity (some dosoge ond indicotions os for normol, full-term infonts).
- Recent exposure to on infectious diseose.
- History of penicillin or other non-specific ollergies or fomily history of such ollergies.

Improving Immunization Coverage

Maintaining high levels of vaccination in preschool children requires the use of multiple strategies implemented by numerous partners in public and private-sector organizations and health-care providers at the national, state, and local levels. Oklahoma physicians play a major role in this effort. The Oklahoma 1999 Immunization Survey of Two-Year-Olds indicates that 42% of all survey respondents received their immunizations through private physicians, compared to 33% from Health Departments and the remainder in various other settings. Physicians can maximize their immunization efforts through a variety of strategies such as:

(a) Utilize every clinical encounter to assess immunization status and deliver appropriate vaccines. Office staff can be trained to screen records of all daily patient visits and inform the physician about needed vaccinations, or have standing orders for vaccine administration. This is especially important when seeing persons with limited access to routine medical care, such as poor and minority patients.

(b) Emphasize to parents the need for children to return for *all* immunizations, generally at 2, 4, 6, 12 to 18 months, and 4 to 6 years of age. Providing parents with information about the safety and efficacy of vaccines can help to enhance compliance.

(c) Avoid inappropriate contraindications for vaccination. Table 4 lists many conditions that, although commonly thought to be so, are not contradictions to vaccination.

(d) Utilize electronic programs designed to improve immunization delivery and keep clinicians abreast of current vaccine recommendations. Two such programs include the Oklahoma State Immunization Information System (OSIIS) from the Oklahoma State Department of Health (OSDH), and the "Make Every Visit Count" program, a collaborative effort by the CDC and the American Academy of Pediatrics.

New Vaccine Recommendations for Children: Hepatitis A and B, Varicella, Pneumococcal Disease

Hepatitis A

Hepatitis A is one of the most commonly reported infectious diseases in the state, with an average of 350 to 400 cases reported each year. Also, epidemics of the disease occur about every 8 to 10 years, the most recent of which took place from 1995 to 1997, affecting 53 of the state's 77 counties and resulting in almost 6,000 cases of hepatitis A in Oklahoma residents. Although the epidemic is now behind us, we are left with a clear reminder of how infectious diseases can spread through an unimmunized population. After close analysis of this outbreak, it was concluded that the only way to achieve long-term control of hepatitis A in Oklahoma was to maintain high levels of immunity in the general population, and that the only way to accomplish that was to require hepatitis A vaccination for school attendance. Consequently, in 1998 Oklahoma became the first state in the United States to add hepatitis A vaccine to school immunization requirements. The requirement was instituted in two grade-cohorts per year. Beginning in the fall of 1998, students entering kindergarten and 7th grades were required to receive the two-dose vaccine. Each year thereafter the requirement is extended one grade level so that by the 2004 school year all children entering school will be required to have the vaccine. In 1999, hepatitis A vaccine was added as a requirement for attendance at daycare centers. Hepatitis A vaccine is very safe and effective and should be considered for anyone who wishes to avoid the disease, especially those persons at increased risk for the disease or for complications from the infection, such as persons with chronic liver disease (Table 5).

Hepatitis B

Hepatitis B virus (HBV) is a significant health problem in the United States, with about 20,000 cases reported annually and 200 to 300 deaths from acute fulminant hepatitis. The consequences of chronic infection, which occurs in about 10% of cases, are also significant—each year in the

Table 5. Hepatitis A and B: High-Risk Graups ta Cansider far Vaccinatian

Hepatitis A	Hepatitis B
Persons in cammunities with rotes > 20/100,000/yeor	Homosexual men
Internotionol trovelers[1]	Heterasexuols with multiple sexuol contocts
Homosexual men	Injection drug users
Injection ond noninjection drug users	Hemodiolysis potients
Persons with clotting foctor disarders	Person with clotting foctor disorders
Persons with occupotionol risk[2]	Household ond sexuol contocts of HBV corriers
Persons with chranic liver diseose	Persons with occupotionol blood contoct
	Clients ond staff in institutians for the developmentolly disobled
	Long-term mole prison inmotes
	Internotionol trovelers[3]
	Persons with chranic liver diseose

1 Includes oll countries except Australio, Conodo, Jopon, New Zealond, Scondinovio, ond Western Europe
2 Limited to those working with nonhumon primotes or with hepotitis A virus in laboratory setting. Hepotitis A voccine is not routinely recommended for health-core workers, doycore center employees, or food handlers
3 For trovel to oreos of high HBV endemicity of > 6 months ond close contoct with locol populotion, or shorter time if sexuol contocts expected

United States an estimated 3,000 to 4,000 persons die of HBV-related cirrhosis, while 1,000 to 1,500 die from HBV-related liver cancer.[9] Children infected with HBV are at much greater risk of becoming chronic carriers. Although a vaccine has been available since 1981, programs focused on providing the vaccine to high-risk persons have had little impact on the overall incidence of the disease. Consequently, a comprehensive hepatitis B prevention program has been implemented that includes (a) routine vaccination of infants, (b) prenatal testing of women for HBsAg to identify newborns who are at high risk of perinatal infection, (c) vaccination of certain adolescents, and (d) vaccination of adults at high risk of infection.

Primary vaccination of infants consists of three doses of vaccine with the second and third doses given 1 to 3 months and 2 to 17 months after the first. The first dose can be administered during the newborn period, preferably before the infant is discharged from the hospital, but no later than two months of age. Recent concerns about the safety of thimerosal, a commonly used vaccine preservative, resulted in the discontinuation of many hospital policies that provided routine hepatitis B vaccination of newborns. Thimerosal-free hepatitis B vaccine is now available and the CDC and OSDH recommend that hospitals reintroduce routine vaccination of newborns. NIS data indicate that 85.4% of Oklahoma children aged 19 to 35 months have received three doses of hepatitis B vaccine, slightly below the US average of 87% (Table 3).

Perinatal transmission of HBV is very efficient—20% of children born to HBsAg-positive mothers and 70% to 90% of children born to HBsAg- and HBeAg-positive mothers will become infected without appropriate intervention. The CDC estimates that as many as 80 new perinatal hepatitis B cases occur annually in Oklahoma. Hepatitis B immune globulin and vaccine are highly effective in preventing perinatal HBV infection if given within twelve hours of birth, and OSDH will provide both to all infants born to HBsAg-positive mothers. In order to identify at-risk infants, USPSTF and CDC strongly recommend that *all* pregnant women be screened for HBsAg and positives be reported to the Health Department. It is estimated that a national screening and treatment program would cost $12.6 million annually, but would save $41.8 million and 640 lives each year.[7]

The risk of HBV infection increases during adolescence. To protect this higher-risk group, all children not previously vaccinated with hepatitis B vaccine should be vaccinated at 11 to 12 years of age. In 1997, Oklahoma initiated a hepatitis B vaccine school requirement for 7th graders. In 1998, the requirement was extended to kindergarten also, and has been extended one grade level per year since then, similar to hepatitis A vaccine. The vaccine is also required for daycare attendance.

Varicella

Varicella is endemic in the United States and, because it is highly contagious, virtually all persons contract varicella by adulthood. Although generally mild and self-limited, the risk of complications, including death, is much greater in persons > 15 years and < 1 year of age. Varicella vaccine is recommended for all children without contraindications at 12 to 18 months of age. It may be given to all children of this age regardless

of prior history of varicella, but is not necessary in children with a reliable history of chickenpox. A single dose is recommended for children less than 13 years old; after that age, a booster 4 to 8 weeks following the initial dose is recommended.[10] NIS data reveal that coverage of 19- to 35-month-olds with varicella vaccine is the lowest of any of the recommended vaccines, with about 50% of Oklahoma children and 43% of US children having received it.[8] One dose of varicella vaccine was added as a requirement for Oklahoma students entering kindergarten beginning with the fall 1998 school year. It is also required for daycare attendance.

Pneumococcal Disease

In February 2000, a 7-valent pneumococcal polysaccharide-protein conjugate vaccine (PCV7; Prevnar,™ marketed by Wyeth Lederle Vaccines) was licensed for use in infants and young children. ACIP recommends the vaccine for all children aged 2 to 23 months and for children 24 to 59 months who are at increased risk for pneumococcal disease. The vaccine has not been studied in older children or adults and is therefore not recommended for use in persons aged ≥ 5 years at this time. Persons aged ≥ 5 years who are at increased risk for serious pneumococcal disease should continue to receive 23-valent polysaccharide vaccine in accordance with previous recommendations. PCV7 is felt to be safe and highly efficacious in preventing invasive pneumococcal disease, and is effective in preventing a portion of acute otitis media and pneumonia cases among healthy infants and children.[11] The recommended vaccination regimen for infants is 4 doses given at 2, 4, 6, and 12 to 15 months.

Immunizations for Adolescents

The term adolescent generally refers to persons aged 11 to 21 years. Since most vaccine programs focus on younger as opposed to older children, adolescents may not receive vaccines recommended for their age group, putting them at risk for vaccine-preventable diseases. To address this problem, the Advisory Committee for Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and others have recommended that all practitioners establish a routine visit for all adolescents at 11 to 12 years of age.[12] One of the main reasons for that visit is to update vaccination status. Specifically, the purpose of this visit is to ensure adequate vaccination for:

- Varicella;
- Hepatitis B;
- 2nd dose MMR;
- Tetanus and diphtheria toxoid (Td) booster; and
- Other vaccinations that may be indicated due to demographic or personal health risk factors.

This visit can also be used to provide other important preventive services for adolescents, such as counseling about tobacco, alcohol and other drugs, sexually transmitted diseases, the importance of wearing a seat belt, and other age-appropriate messages or services.

Immunizations for Adults

Approximately 45,000 adults in the United States die annually due to pneumococcal disease, influenza, and hepatitis B—the primary vaccine-preventable diseases affecting adults.[13] Other vaccine-preventable diseases that may affect adults in the United States include tetanus, diphtheria, hepatitis A, and rubella.

Pneumococcal disease

Streptococcus pneumoniae (pneumococcus) is a major cause of significant morbidity and mortality. Each year in the United States, pneumococcal disease causes an estimated 500,000 cases of pneumonia, 50,000 cases of bacteremia, 3,000 cases of meningitis, and results in an estimated 40,000 deaths.[14] It is one of the leading causes of pneumonia and the most common cause of nursing home-acquired pneumonia.[15] For Oklahoma in 1998, pneumonia was the leading reason (excluding childbirth) for all hospitalizations (19,116) and the most common cause of in-hospital death (1,253).[16]

The CDC estimates that about 50% of the deaths due to *S. pneumoniae* could be prevented by wider use of the 23-valent polysaccharide pneumococcal vaccine (PPV23, as opposed to PCV7 discussed above for use in children < 5 years of age). The vaccine protects against invasive disease from 23 serotypes of *S. pneumoniae*, providing coverage for 88% of the strains that cause invasive disease in the United States. Pneumoccal vaccine usage is even more important today because of increasing levels of pneumococcal antibiotic resistance.

USPSTF and all major authorities recommend immunizing all adults over age 65 and other individuals at high risk with the pneumococcal vaccine (Table 6). However, less than half of the US population 65 and older has received the vaccine. Oklahoma ranks near the bottom compared to other states with a pneumococcal vaccine coverage rate for seniors of only 40.4% (rank 42nd in United States)

Table 6. Immunization Recommendations for Individuals at High Risk for Influenza and/or Pneumococcal Disease

Group	Annual influenza vaccine[1]	Pneumococcal vaccine[2]
Specific age groups	Yes, ≥ 50 years	Yes, ≥ 65 years
Residents of chronic care facilities	Yes	Yes[3]
Chronic medical conditions	Yes[4]	Yes[5]
Diabetes mellitus	Yes	Yes
COPD	Yes	Yes
Asthma	Yes	No
Pregnancy	Yes[6]	No
Asplenia, functional or anatomic	No	Yes
Sickle cell disease and other hemoglobinopathies	Yes	Yes
Immunosuppression (including HIV)	Yes	Yes
Household members of high-risk patients	Yes	No
Healthcare providers of high-risk patients	Yes	No

1 Influenza vaccine is not recommended for infants under 6 months old regardless of risk factors.

2 23-valent polysaccharide pneumococcal vaccine (PPV23) is not recommended for children under 2 years old regardless of risk factors. The vaccine is generally given only once; one-time revaccination may be indicated if the first vaccine was given prior to age 65 years and at least five years have passed.

3 If greater than 65 years of age or have chronic medical conditions.

4 Including disorders of the cardiac, pulmonary, and renal systems. Also, children age 6 months to 18 years receiving long-term aspirin therapy who are at risk of Reye Syndrome after influenza infection.

5 Including disorders of the cardiac, pulmonary, renal, and hepatic systems. Other conditions include alcoholism and CSF leaks.

6 Women who will be in the second or third trimester of pregnancy during the influenza season.

according to the 1997 Behavioral Risk Factor Surveillance System (BRFSS).[8] Persons at particularly high risk for pneumococcal disease are those with chronic obstructive pulmonary disease (COPD). COPD death rates in our state have soared since 1975, going from 16.2/100,000 to 33.5/100,000 in men and from 5.1/100,000 to 19.1/100,000 in women. Although efforts aimed at decreasing tobacco use are the primary means of decreasing the prevalence of COPD, increased use of the pneumococcal vaccine could have a significant impact on COPD morbidity (including decreased hospitalizations) and mortality.

Oklahoma physicians must play a major role if we are to increase our pneumococcal vaccination rates. Methods in which they can assist this effort include: (a) screen all personal patients in office and hospital for pneumococcal vaccine status and vaccinate if indicated; (b) work with local hospitals to establish standing orders to screen and vaccinate inpatients and outpatients; (c) for physicians who cover nursing homes, screen and vaccinate all residents (pneumococcal vaccine is indicated for virtually all nursing home residents).

For adults, the pneumococcal vaccine is certainly one of the easiest and most beneficial preventive interventions we can employ. The vaccine is readily available, safe, efficacious, cost-effective, and also reimbursable by Medicare. With a minimum of effort, physicians can markedly decrease the impact of this disease on high-risk patients in our state.

Influenza

Influenza is still a killer—epidemics can claim upwards of 40,000 excess deaths nationwide.[17] It is also a major cause of excess hospitalization and represents a significant economic burden for health-care services. Like pneumococcal disease, influenza poses particular risks to older individuals and to those with COPD and other chronic diseases. In 2000, the CDC began recommending yearly influenza vaccine for all individuals age 50 years and over (as opposed to the previous recommendation for persons age 65 and over), as well as those under 50 at higher risk (Table 6).

Oklahoma does fairly well in providing influenza vaccine to seniors—69.3% of persons aged 65 and over reported that they had received the vaccine during the previous 12 months, compared to the national median of 66%.[8] But influenza is an ongoing challenge and vaccination efforts must be re-instituted every year prior to the influenza season. In Oklahoma, influenza activity generally occurs between late October and April, with the greatest activity in December and January. Immunization efforts are recommended to begin in late October and to continue through November and December. Physicians can help protect their patients from influenza by vaccinating vulnerable populations prior to and during the influenza season. Similar methods as described above for pneumococcal vaccine can be applied before and during the influenza season to improve vaccine delivery.

Table 7. Selected Diseases for which Prophylaxis of Contacts may be Indicated

Disease	Prophylaxis
Tuberculosis	Isoniozid
H. influenzoe Type b	Rifompin
Meningococcol infection	Rifompin or ceftrioxone
Hepotitis A	Immune globulin
Hepotitis B	Hep B Immune globulin ond voccine
Influenzo A	Amontodine; rimontodine
Pertussis	Erythromycin
Nongonococcol urethritis	Azithromycin or doxycycline
Mucopurulent cervicitis	Azithromycin or doxycycline
Gonorrheo	Ceftrioxone, cefixime, or ciprofloxacin, plus ozithromycin or doxycycline
Syphilis (Primory or secondory)	Benzothine penicillin

Hepatitis B

In the United States, most persons contract HBV as adolescents (ages 11 to 21) or young adults (ages 22 to 39 years), primarily due to recreational drug use and unprotected sexual activity among members of this age group. Other risk factors include household contact and occupational exposure (ie, health care workers). However, one-third of those with acute hepatitis B have no identifiable source of infection. Both the USPSTF and the AAP recommend that clinicians administer hepatitis B vaccine to all adolescents and young adults who have not been previously immunized. For older adults, persons with certain high-risk behaviors or characteristics should be immunized (Table 5). Also, individuals infected with hepatitis C are candidates for hepatitis B vaccination, particularly if they have other risk factors for HBV.

Hepatitis A

Table 5 lists the persons at increased risk for hepatitis A for whom the vaccine is recommended. An important use of hepatitis A vaccine is in persons with underlying chronic liver disease (such as chronic hepatitis B or C, or alcoholic liver disease) since they are at increased risk of severe disease and death if they contract hepatitis A. It is important to keep in mind that the prevalence of natural immunity to hepatitis A increases with age, such that by the time a person reaches the age of 50, there is a 33% chance that they have already been exposed to hepatitis A and are immune.[18]

Rubella

Because of the enormous risks from intrapartum rubella infection, all women of childbearing age should have this immunization. The USPSTF recommends that immunization (or assessment of immune status) be performed for all such women at their first clinical encounter.

Tetanus

Although tetanus is rare in the United States (about 50 cases/year reported in the US), it carries a risk of serious morbidity and a mortality rate of about 25%. Physicians can decrease this risk by assuring that their patients receive periodic boosters for tetanus/diphtheria (Td). Although Td boosters are generally recommended every 10 years, USPSTF suggests that if persons received the standard five-dose regimen in childhood then boosters every 15 to 30 years are probably adequate.[4] Two groups that are at increased risk for tetanus include the elderly (due to waning immunity) and IV drug users.

Diphtheria

Diphtheria is extremely rare in the United States but outbreaks continue to occur in other parts of the world. Epidemic diphtheria has re-emerged in parts of the former Soviet Union with as high as 50,000 cases per year.[9] Diphtheria thus remains a concern here due to the ease of international travel and the possibility of imported cases. A Minnesota study showed that 62% of individuals 18 to 39 years old lack adequate protection against diphtheria.[19] The threat of diphtheria re-emergence is another compelling reason to provide Td vaccination to adults.

Chemoprophylaxis

This article has focused on the use of vaccines for the primary prevention of infectious diseases. However, there are times in which persons have been exposed to diseases for which vaccines either do not exist or will not provide protection against the recent exposure. In these instances, prophylactic medications (most often an antibiotic or immune globulin) may be recommended to decrease the likelihood that the exposed person will develop the disease. It is beyond the scope of this article to discuss every situation where chemoprophylaxis is recommended. Table 7 lists the most common infectious diseases for which effective chemoprophylaxis is available and may be indicated depending upon the circumstances. We encourage physicians to consider the need for prophylaxis of contacts when they see patients with infectious diseases. For guidance on prophylactic regimens, physicians may refer to established references[20,21] or consult with the Health Department.

Other types of chemoprophylaxis exist for noninfectious processes, such as the use of supplemental estrogen in postmenopausal women to prevent osteoporosis, low-dose aspirin in persons with coronary artery disease to prevent myocardial infarction, and folic acid in women of child-bearing age to prevent neural tube defects. USPSTF concluded that available data did not support the routine use of supplemental estrogen or aspirin in all at-risk persons but that physicians should discuss the benefits and side-effects with all patients that may benefit from their use. For neural tube defects, USPSTF felt that the preventive benefits of folic acid were clearly defined and consequently recommended that all women who are planning or capable of pregnancy take a daily multivitamin containing folic acid. This issue was discussed in more length in Part I of this series.[2]

Conclusions

It can be argued that vaccinations have had a bigger impact upon improving the health of humankind than any other biomedical technology. But despite remarkable achievements, many challenges remain. Our vaccine-delivery infrastructure must be capable of handling an increasingly complex vaccination schedule. An estimated 11,000 children are born each day in the United States (130 in Oklahoma), each requiring 15 to 19 doses of vaccine by age 18 months to be protected against 11 childhood diseases (not counting the new pneumococcal conjugate vaccine); and licensure of other vaccines is expected.[6] To achieve the full potential of vaccines, parents must recognize the importance of immunization and seek vaccination for their children; clinicians must be aware of current vaccine recommendations and seek ways to facilitate vaccine delivery to their patients; vaccine financing must be made secure; researchers must address increasingly complex questions about safety, efficacy, and vaccine delivery, and harness the power of information technology to support timely vaccinations. Also, the vaccine delivery system must be extended to new populations of adolescents and adults.[6] The challenges are great, but so are the potential benefits.

Although vaccination rates are at an all-time high, we are still far short of the national goal of having 90% of our children up-to-date with routine vaccines by their second birthday. Achieving that goal in Oklahoma will require a combined effort between public- and private-sector health professionals. Paramount to that effort is an ongoing vigilance by practicing physicians to the vaccination needs of their patients.

Final Remarks Regarding the "Improving the Health of Oklahomans" Series

Our primary goal for this series of articles has been to promote the use of scientifically-proven effective preventive interventions by Oklahoma physicians in the context of their clinical practice. The evidence we have presented indicates that this is an underutilized yet powerful means of addressing some of the major health problems confronting Oklahomans. We have argued that prevention is state-of-the-art medicine, utilizing the most current medical knowledge in order to decrease the risk of disease and/or intervene in disease processes as early as possible. Both of these strategies typically result in better outcomes for our patients. But we have also asserted that prevention efforts should be focused. Although few would argue with Benjamin Franklin's famous quote that, "an ounce of prevention is worth a pound of cure," most physicians can also empathize with the updated assessment that, "an ounce of prevention is a ton of work." Facing greater time pressures than ever before, physicians can be most time-effective by prioritizing preventive interventions of documented efficacy in patients who are at increased risk for specific health-related outcomes. Clearly, it is not feasible or desirable to provide all preventive services to all patients—focused efforts are a more effective use of limited time and resources.

Admittedly, there are still many obstacles to the provision of preventive services in the United States. Hopefully these can be resolved in time. But in the mean time, physicians should strive to employ those preventive services they have at their disposal. We believe that not only is this "good medicine" and in the best interest of individual patients, but can also improve the "state of our state's health." ▯

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Vaccine-Preventable Diseases

In the United States we have record or near-record low levels of vaccine-preventable childhood diseases, but this does not mean these diseases have disappeared. Many of the viruses and bacteria that cause these diseases are still circulating in this country or are only a plane ride away. For this reason it is important for children, especially infants and young children, to receive recommended immunizations on time. In our mobile society, more than a million people each day travel to and from other countries, including countries where many vaccine-preventable disease remain relatively common. Without vaccines, epidemics of many preventable diseases could return, resulting in increased—and unnecessary—illness, disability, and death among children.

But vaccines aren't just for kids. Far too many adults become ill, are disabled, and die each year from diseases that could easily have been prevented by vaccines. Everyone from young adults to senior citizens can benefit from immunizations, but some immunizations are vital for most adults, especially senior citizens. Others are only appropriate for certain people.

The following information is provided to help you identify which vaccines you (or your child) should already have or may need to receive.

Diphtheria
Diphtheria is a respiratory disease caused by bacteria that is spread by coughing and sneezing. Children should receive 4 vaccinations against diphtheria (as part of the diphtheria, tetanus, pertussis—DTP—vaccine) by the age of two. Adults also need to be vaccinated against diphtheria: if you have not had a booster shot in 10 years or more, or never had the initial 3-shot series, you should be vaccinated.

***Haemophilus influenzae* type b (Hib)**
Hib is a severe bacterial infection that occurs primarily in infants and is spread by coughing and sneezing. Children should receive 4 vaccinations against Hib by the age of two. Most people over five years of age do not need Hib vaccine; however, if you have sickle cell anemia, or if your immune system is weakened (due to HIV/AIDS or other diseases that affect the immune system; treatment with drugs such as long-term steroids; cancer treatment with x-rays or drugs; bone marrow or organ transplant; or damaged/no spleen) you should receive the Hib vaccine.

Hepatitis A
Hepatitis A is a disease of the liver caused by the hepatitis A virus; most often it is spread by the fecal-oral route (where an object contaminated with the stool of a person with hepatitis A is put into another person's mouth), but can also be spread by swallowing food or water that contains the virus. It is recommended that children receive the hepatitis A vaccine. Adults who meet the following conditions should also receive the vaccine: you have long-term liver disease; you travel to countries with high rates of hepatitis A; you are a man and have sex with a man; you use street drugs; you live in a community with a high rate of hepatitis A; or you receive blood products to help your blood clot.

Hepatitis B
Hepatitis B is a disease of the liver caused by the hepatitis B virus and is spread through contact with the blood of an infected person or by having sex with an infected person. Children should receive 3 vaccinations against hepatitis B by the age of two. Adults should receive the hepatitis B vaccine if: you have had sex with more than one person in the last six months; you have had a sexually transmitted disease; you are a man who has sex with other men; you are the household contact or sex partner of a person with long-term hepatitis B; you have a job that involves contact with human blood; you are on the staff of, or a client in, an institution for the developmentally disabled; you are the recipient of certain blood products; you are a dialysis patient; you live or travel for more than six months a year in countries where hepatitis B is common; you are a prisoner in a long-term correctional facility; or you use street drugs.

Influenza
Influenza (also known as "flu") is a highly infectious viral illness that is spread by contact with an infected person or the airborne virus. Anyone over the age of six months wanting to reduce their risk of catching influenza should get the vaccine, especially if: you are over 65 years old; you are living in a long-term care facility for the chronically ill, no matter what your age; you have a serious long-term health problem with heart disease, lung disease (including asthma), metabolic disease (such as diabetes), anemia or other blood disorders, or kidney diseases; your immune system is weakened because of HIV/AIDS or other diseases that affect the immune system, treatment with drugs such as long-term steroids, cancer treatment with x-rays or drugs, or bone marrow or

Ten Things You Need to Know About Immunizations

1. Why should my child be immunized?
Children need immunizations (shots) to protect them from dangerous childhood diseases. These diseases have serious complications and can even kill children.

2. What diseases do vaccines prevent?
Measles, mumps, polio, rubella (German measles), pertussis, diphtheria, tetanus, *haemophilus influenzae* type b (Hib disease), hepatitis B, and varicella (chickenpox).

3. How many shots does my child need?
The following vaccinations are recommended by age two and can be given in five visits to a doctor or clinic:

- 1 vaccination against measles/mumps/rubella (MMR);
- 4 vaccinations against Hib (a major cause of spinal meningitis);
- 3 vaccinations against polio;
- 4 vaccinations against diphtheria, tetanus, and pertussis (DTP);
- 3 vaccinations against hepatitis B; and
- 1 vaccination against varicella.

4. Are the vaccines safe?
Serious reactions to vaccines are extremely rare but do occur. However, the risks of serious disease from not vaccinating are far greater than the risks of serious reaction to the vaccination.

5. Do the vaccines have any side effects?
Yes, side effects can occur with vaccination, depending on the vaccine: slight fever, rash, or soreness at the site of the injection. Slight discomfort is normal and should not be a cause for alarm. Your health care provider can assist you with further information.

6. What do I do if my child has a serious reaction?
If you think your child is experiencing a persistent or severe reaction, call your doctor or get the child to a doctor right away. Write down what happened and the date and time it happened. Ask your doctor, nurse, or health department to file a Vaccine Adverse Event Report form, or call 800/338-2382.

continued

Patient Handout #12

7. Why can't I wait until school to have my child immunized?
Immunizations must begin at birth and most vaccinations completed by age 2. By immunizing on time (by age 2), you can protect your child from being infected and prevent the infection of others at school or at daycare centers. Children under 5 are especially susceptible to disease because their immune systems have not built up the necessary defenses to fight infection.

8. Why is a vaccination health record important?
A vaccination health record helps you and your health care provider keep your child on schedule. A record should be started at birth when your child receives his/her first vaccination, and updated each time your child receives the next scheduled vaccination. This information will help you if you move to a new area or change health care providers, or when your child is enrolled in daycare or starts school. Remember to bring this record with you every time your child has a health care visit.

9. Where can I get free vaccines?
The Vaccines for Children program will provide free vaccines to needy children. Eligible children include those without health insurance coverage, all those who are enrolled in Medicaid, American Indians, and Alaskan Natives.

10. Where can I get more information?
You can call the National Immunization Information Hotline for further immunization information at 800/232-2522 (English) or 800/232-0233 (Spanish).

organ transplants; you are a doctor, nurse, visiting home nurse, volunteer worker, family member, or someone else who comes in close contact with a person at risk of serious flu; you will be more than three months pregnant during flu season; you provide essential community services (eg, firefighers, police); you travel to the southern hemisphere between April and September, or to the tropics at any time; or you are a student or staff member of a school or college.

Lyme Disease
Lyme disease is an infection caused by a germ from certain kinds of ticks; it is spread by certain kinds of ticks. After three doses, Lyme disease vaccine protects three out of four people from this disease. You should get the Lyme disease vaccine if: you are 15 to 70 years of age; you live, work, or play in areas surrounded by woods or overgrown brush infested by certain ticks (this disease is most common in the northeastern, mid-Atlantic, and upper north-central regions of the United States, and some parts of northwestern California); or you are in the described tick regions often or for long periods.

Measles
Measles is a respiratory disease caused by a virus that is highly contagious and spread by coughing and sneezing. Children should receive 1 vaccination against measles (as part of the measles, mumps, rubella—MMR—vaccine) before the age of two. As an adult you do NOT need the MMR vaccine if: you had blood tests that show you are immune to measles, mumps, and rubella; you are a man born before 1957; you are a woman born before 1957 who is sure she is not having more children, has already had rubella vaccine, or has had a positive rubella test; you already had two doses of MMR or one dose of MMR plus a second dose of measles vaccine; or you already had one dose of MMR and are not at high risk of measles exposure. You SHOULD get the measles vaccine if you are not among the categories listed above and: you are a college student, trade school student, or other student beyond high school; you work in a hospital or other medical facility; you travel internationally, or are a passenger on a cruise ship; or you are a woman of childbearing age.

Mumps
Mumps is a disease of the lymph nodes caused by a virus; it is spread by coughing and sneezing. Children should, by the age of two, have received 1 vaccination against mumps as part of the MMR vaccine. Recommendations for adult vaccination against mumps are the same as those for measles (see above).

Pertussis
Pertussis (whooping cough) is a respiratory disease caused by bacteria that is highly contagious and spread by coughing and sneezing. Children should receive 4 vaccinations against pertussis by the age of two as part of the DTP vaccine.

Pneumococcus
Pneumococcus is a type of bacteria that exists in many people's noses and throats that, for some unknown reason, may suddenly invade the body and cause disease. You should get the pneumococcal vaccine if: you are 65 years old or older; you have a serious long-term health problem such as heart disease, sickle cell disease, alcoholism, leaks of cerebrospinal fluid, lung disease (not including asthma), diabetes, or liver cirrhosis; your resistance to infection is lowered due to Hodgkin's disease, multiple myeloma, cancer treatment with x-rays or drugs, treatment with long-term steroids, bone marrow or organ transplant, kidney failure, HIV/AIDS, lymphoma, leukemia or other cancers, nephrotic syndrome, damaged/no spleen; or you are an Alaskan Native or from certain Native American populations.

Polio
Polio is a disease of the lymphatic and nervous systems that is transmitted by contact with an infected person. Children should receive 3 vaccinations against polio by the age of two; adults should receive the polio vaccine if: you are traveling to polio-infected areas of the world; you are working in polio laboratories; or you are changing the diapers of a child who is receiving the oral polio vaccine (OPV).

Rubella
Rubella (also known as German measles) is a respiratory disease caused by bacteria that is spread by coughing and sneezing. Children should receive 1 vaccination against rubella (as part of the MMR vaccine) by the age of two. Recommendations for adult vaccination against rubella are the same as those for measles (see above).

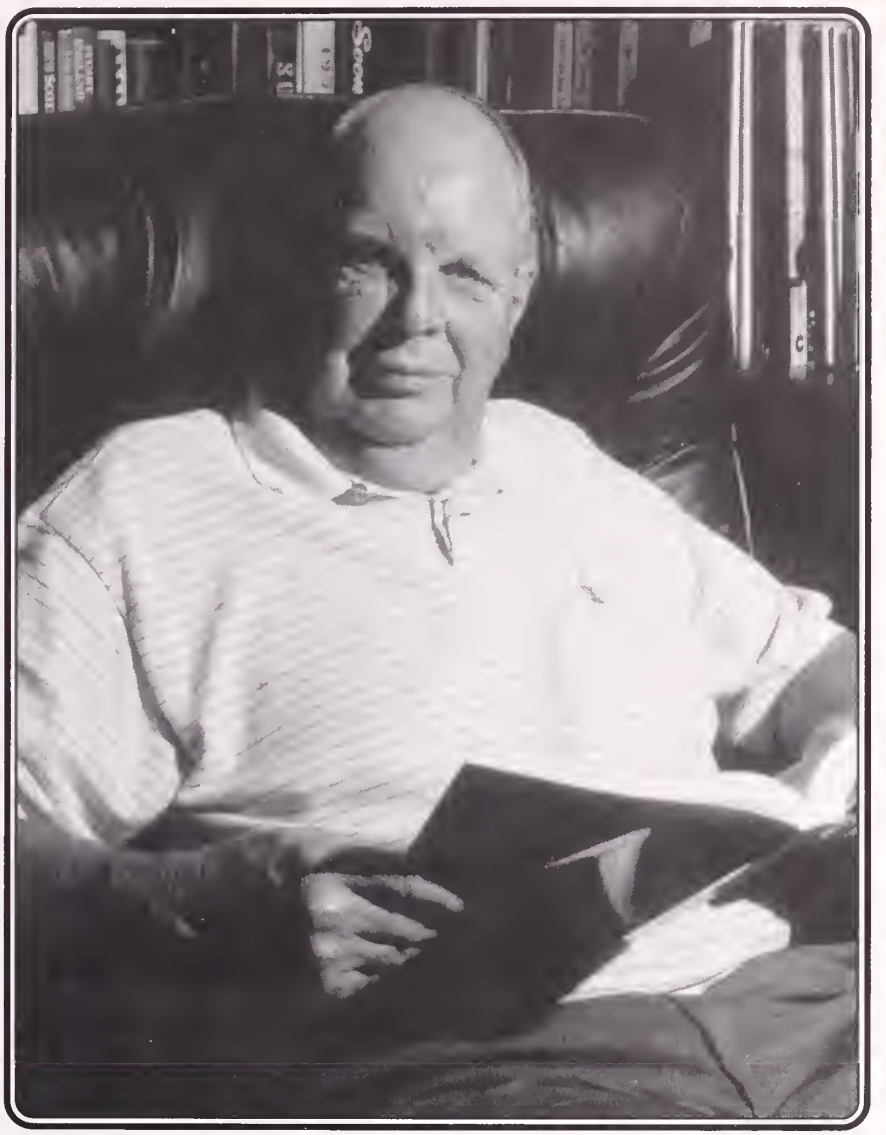
Tetanus
Tetanus (lockjaw) is a disease of the nervous system caused by a bacteria; it enters the body through a break in the skin. Children should receive 4 vaccinations against tetanus as part of the DTP vaccine by the age of two. Adults who have not had a tetanus booster shot in ten years or more, or who never had the initial 3-shot series, should be vaccinated.

Varicella
Varicella (chickenpox) is a virus of the herpes family and is spread by coughing and sneezing. Children should receive 1 vaccination against varicella by the age of two; adults should receive the varicella vaccine if you do not have a reliable history of having had chickenpox and: you are a health care worker, teach young children, a day care worker, a resident or staff member in an institution setting, a college student, an inmate or staff member of a correctional institution, in the military, or if you travel internationally; or you are a woman of childbearing age and are sure you are not pregnant (pregnant women should not receive the varicella vaccine).

Patient Handout #12

Source: Centers for Disease Control and Prevention, National Immunization Program. Available at: www.cdc.gov/nip.

Leaders in Medicine



Floyd Miller, MD

Story by Richard Green

Despite the fact that Floyd Miller was not quite a teenager when America entered World War II, it is clear in retrospect that the Great Depression had an indelible influence on the man he would become.

Of course, he did not know this then; now, at age 70, Dr. Miller has probably still not given much thought to whether nature or nurture has influenced his life more. But the few people who have known him both well and at length would probably agree it is very close to a fifty-fifty split.

Dr. Miller inherited a lively intelligence that is a boon to anyone wanting to excel. Many of his ancestors were college graduates. His paternal grandfather was a law school graduate, noted newspaperman, judge, lawmaker, and poet of some repute. His parents both attended the University of Oklahoma. His father had a master's degree, was an educator, and owned a respected newspaper.

The Millers had already produced three attractive and highly intelligent daughters when finally they had a son. But by the time Floyd was born on March 15, 1930, the Depression was settling across the land, forcing even talented and enterprising men like his father to struggle to make ends meet, awaking deep in the night feeling the visceral fear that he and his family could wind up destitute, just like thousands of other American families.

Only nine months later, another catastrophe struck. And, like a stone thrown into a pond, the effects of his father's sudden and untimely death continued to ripple as Floyd grew into manhood. If his father had recovered, Floyd might not have witnessed the daily display of the qualities best employed to combat adversity, including two—loyalty and discipline—that have held an especially prominent place in his life. Dr. Miller says that both of these qualities seem to be out of fashion nowadays. From his tone, it is obvious that he regrets this trend, but—perhaps not wanting to come off as an aging man railing against contemporary society—he appends, "Whether that's good or bad, I can't say."

When Floyd was a cooing nine-month-old infant, his father, a heretofore healthy and vigorous 41-year-old man, developed pneumonia. Slowly, over the course of a week, Dr. Miller's father battled the illness, struggling for each breath. Ultimately he lost the fight. Floyd had never known his father, but his death was pivotal—not because of the hole it left in Floyd's childhood, but because it set the stage for the most remarkable and inspiring role model to come into his life. Although he was never referred to as a "momma's boy," Floyd was his mother's son in the most profound way. And, as a result, to this day he has little to no patience for people who blame their shortcomings or misfortune on the fact that they were raised by only one parent.

Though a family ancestry may be traced back many generations before discovering familial traits, patterns, and influences, in the case of the Miller family, two generations of review will reveal quite a lot. Freeman E. Miller was an accomplished man, exhibiting an aura of such power and control that it might have seemed to the casual observer that nothing of consequence could possibly have occurred before he came along. He was the family progenitor, at the least in spirit if not also in fact.

Of his grandfather Floyd said, "you either loved him or hated him." When asked which side he was on, Floyd said, "I respected him."

Born during the Civil War in Indiana, Freeman Miller received his law degree while still in Indiana before setting off to seek his fortune. He came to the Oklahoma territory during the Land Run of 1889 and settled in Stillwater. He strongly favored joining Oklahoma and Indian territories into a single state and later, as a member of the Territorial Council, he played an active role in drafting legislation that was enacted by the first state

legislature. In his obituary, Freeman was credited with being the principal author of Oklahoma's Prohibition Enforcement Act, which banned alcoholic spirits in the state.

Freeman was certainly no redneck. He taught English at Oklahoma A&M College before statehood and served as the department chair during World War I. From 1905 to 1917, he owned and operated two successive newspapers in Stillwater and twice ran—unsuccessfully—for the state legislature. In his newspapers Freeman began publishing his poetry and was unofficially known as the "poet laureate of Oklahoma." From 1905 until 1917, he wrote a weekly column for *The Daily Oklahoman.*

Otherwise, Freeman practiced law and was active in Democratic politics. In 1931, at the age of 68, he was appointed district judge for Payne and Logan counties by Governor William H. Murray. This was only a month after the tragic death of his 41-year-old son, Floyd. Floyd's wife, Elsie Miller, was left to raise four children, including the baby Floyd Freeman Miller. Growing up in Skiatook, Floyd didn't often see his grandfather. When he did—always at Memorial Day for some reason—Freeman held forth on politics, government, law, international affairs, art...you name it.

While Floyd admired his grandfather's intellect and loved listening to him pontificate, the old man's shortcomings were evident. He was rigid, demanding, and distant. By the time he was 70, Freeman was on his fifth marriage, this time to a woman in her twenties. It was about that time that Floyd learned that after his father died, his prosperous grandfather never offered his mother, Elsie, any financial assistance or emotional support.

Nevertheless, a few years later, Floyd decided during some very trying circumstances that he had to go to his grandfather for help. Was it galling to go to the man who had not reached out to his mother in her time of need? It was, Floyd says, "necessary."



The young Floyd Miller sits atop the pony of a door-to-door photographer in the days before medicine became his life's work.

Freeman's son, Floyd E. Miller, put himself through college, becoming a teacher, then a school superintendent. While studying for a master's degree at the University of Oklahoma, he met and married another OU student, Elsie Rader. In 1918 the couple moved to Jenks, where Floyd founded a newspaper. The Millers started their family by having two girls, three years apart. Eight years later they had another girl. In 1922, the family moved to Skiatook and Floyd acquired the *Skiatook News.*

In addition to running the paper, Floyd served as president of the chamber of commerce and was active in the Democratic party. Like his father, he ran unsuccessfully for the state legislature. In March 1930, the family was completed with the birth of a son, Floyd Freeman Miller. The senior Floyd made another unsuccessful bid for a position in the state legislature; a few months later he developed what would prove to be a fatal case of pneumonia. "Back in those days," says his son and namesake, "there was no treatment for pneumonia, so you either lived or died. Most lived. He didn't."

Elsie leased out the newspaper and took care of her son. But when Floyd was five, she entered him in kindergarten, hired a linotype



Floyd and Mary Adeline met on a blind date during Floyd's senior year at the University of Oklahoma and were married about a year later—and have been ever since.

operater, and began running the newspaper herself. It was a family newspaper in every sense: every Miller helped—including Floyd, when he got old enough. In high school he found himself in the unusual situation of playing in the school baseball and basketball games, only to then report on them for the paper.

He liked sports and enjoyed the reporting, so he figured he would become "a big-shot sports writer." He also wrote some crime stories in his spare time, which he shared with his sister and editor, Lorraine. (Recently, more than half a century later, Floyd found this literary treasure trove and reread his early works of crime fiction. He says he disposed of some on the spot. "The rest you'll never see," he laughs.)

By the time Floyd was working at the newspaper, his two older sisters were grown and had moved away. After school, Floyd and his sister Phyllis did the shopping and cooking. "Mother gave us one dollar a day and that's what the family lived on," he recalls.

Making ends meet during the Depression was always tough and it required everyone to live in a very disciplined way. But Floyd says it was even more difficult for his mother to keep the paper going after the United States entered World War II. "Most of the advertising dried up because of rationing," Floyd says. "I think Mother kept the *News* going for the boys who were fighting in the war. It was her contribution to the war effort. The paper kept our local boys informed about what was going on at home and mother printed letters from the servicemen who were in the war."

Still, without the continued advertising of the PSO, the company that provided electricity to Skiatook, the newspaper would have folded. After the war, when Skiatook city officials decided to take over distribution of electricity themselves and asked Elsie to write an editorial favoring this approach, she refused out of loyalty, even though she knew local distribution made sense economically for Skiatook.

Elsie not only kept the paper going against great odds, but she also saw to it that her children felt safe and secure, and not only survived, but excelled. All four were class valedictorians and she would see all three of her daughters graduate from OU. While Floyd was a freshman at OU, she developed cancer. She sold the paper and began taking the bus to Tulsa every day for radiation treatment. She died a slow, painful death, feeling especially bad not for herself, but because her daughters were taking turns leaving their families to take care of her. When Floyd came home from Norman in her final days, he observed an osteopathic physician, who heretofore had never been the family doctor, stopping by every night to check on his patient.

Although the doctor could do little for Elsie medically, he brought her a measure of comfort, Floyd recalls, and given her deteriorating condition, that was no small accomplishment. Though he can't say that he decided at that moment to become a physician, he was starting to think about it. Actually, some OU professors who had noticed his interest in law and politics had encouraged Floyd to go into law. He had a nearly straight-A average, and would eventually be elected to Phi Beta Kappa. His mother's illness and death probably tipped the scales in favor of medicine, though he knew little about

being a doctor except that "you help people" and "make a decent living." What he probably did not know is that a significant number of people who enter medical school have lost a parent or someone close to them.

During his second year at OU, Floyd stopped accepting money from his mother. She needed it to pay for her care. To get by, Floyd washed dishes in his fraternity house but it wasn't enough. This was a very low point in his life. The person he loved and admired most, his mother, was dying and he, despite stellar grades, was contemplating dropping out of OU. It was then that he sought help from his grandfather, Freeman Miller. Floyd explained his situation—how he had made all A's and he wanted to be a doctor. Then he asked for $100 a month. Never one to rush, Freeman told his grandson he would have an answer in due course. Floyd believes that Freeman's wife probably intervened on his behalf. Freeman's written reply was so convoluted that Floyd didn't know if his answer was yes or no until the first check arrived.

Floyd took a broad base of liberal arts courses and majored in sociology, which he believes was excellent preparation for his later life and career. In the summers, Floyd worked in Altus, where his brother-in-law operated a finance company. Floyd's job: automobile repossessor. Though this job would seem to have little value to a future doctor, Floyd says it helped him become a better judge of character. "I faced a lot of shotguns and spent a lot of time late at night waiting for the house lights to go out so that I could hitch up the car in question and tow it off. But I also had the leverage to redo the loan and spent considerable time working with some people, particularly farmers. I hardly ever repossessed a pick-up truck because I knew that without it, that was the end for a farmer. I felt like I had developed the ability to tell the difference between someone who was down on his luck and needed help and the bozo who was frittering away his money." Though Floyd benefited from his "repo" experiences over three summers, he wouldn't call it a good job. "It was interesting...And I'm glad I didn't get killed."

His girlfriend that last summer, Mary Adeline, was glad, too. They met on a blind date during Floyd's senior year. She was using an assumed name in case she didn't like him, but at times she forgot about the fake name and often didn't respond when he called her by that name. "I thought she was just about the dumbest girl I'd ever met," Floyd says. At the end of the date, she fessed up and that changed everything. They were married about a year later and have been ever since.



With the help of his office assistant, Nita Long, Dr. Miller demonstrates a lung test he uses in his allergy practice.

By the time Floyd began his medical studies at OU in 1953, he had all the tools he needed to excel. He took some of the best notes in class, had a powerful memory, and was imbued with self-discipline. He also had a wide range of interests, liked to socialize, was a good listener, and was known as the guy who would go out of his way to help a classmate. He was not only selected for Alpha Omega Alpha, he was its president. Of course, such a student would catch the attention of faculty luminaries such as Dr. Stewart Wolf, OU's first full-time chair of the department of medicine, and Dr. Robert Bird. The feeling was more than reciprocated by Floyd. As a physician, Bob Bird was in a class by himself, according to Floyd. "Not only was he technically superb as a hematologist," Floyd says, "but he communicated with all of his patients, and I mean ALL of them, better and with more compassion than anyone I've ever seen." Bird was not only Floyd's role model

and "hero," he was also his friend. Although socializing with medical faculty was rare for students, Floyd and Adeline entertained Dr. Bird in their home several times.

Dr. Wolf influenced Floyd's career in a different way. After Floyd told him that he hoped to take his residency in a big hospital in a small city, Dr. Wolf arranged for Miller to be accepted—sight unseen—into the internal medicine residency program at the University of Michigan Medical Center in Ann Arbor. As this was one of the best programs in the nation, Dr. Wolf had done him a big favor. But there were plenty of times during the 100+-hour work weeks when Floyd had to concentrate very hard to remember that what he was experiencing was good for him.

The self-discipline Floyd had developed and been practicing most of his life was severely tested at Ann Arbor, and there were times when he worried about his ability to survive the internship and first year of the residency. During one service, tuberculosis surgery, he was on 24 hours a day for a month, losing 30 pounds in the process. He then went to OB, where his schedule was 48 hours on and 24 hours off—a comparative "vacation" in his mind's eye.

The couple's first son, Michael, was born during Floyd's senior year of medical school, while he still had a little time to spend with the new baby. But when they moved to Ann Arbor, Floyd was far too busy to participate in family life. The first two years there were the toughest years of their marriage—not that they were quarreling, because Floyd wasn't around enough for that. As he says, "Basically, I didn't see my wife and son for two years." Their second and final child, Steven, was born after the second year of his residency. The family eked by on Floyd's salary and gifts from Adeline's parents. Floyd's pay was the minimum the law allowed for a state employee—$100 a month.

Looking back, Floyd defends such training programs for two reasons: "You can't be trained adequately in less time. And since you've been through the fire, you know when that call comes from a difficult patient at 2 am, you will do what's best for him or her, not necessarily for you." He wonders if today's residents, whose work load is limited to 80 hours a week, will be able to stand up to the pressures of practice. But, at the same time, he understands that many new doctors prefer to be salaried with regular, limited hours so they can spend more time with their families. "There's nothing wrong with wanting to live a normal life. We certainly didn't live normal lives. I'm not saying we were better—the caliber of students and residents is high—but things are definitely different."

Though the resident's pay caused great hardships on his family, Floyd worries that most residents today already are making more money than many of their patients. "I don't know if that's good or bad," he says, echoing this refrain often when noting the differences between then and now. It seems to be his way of modulating what may otherwise sound like a typical old doctor's screed.

In medical school, Floyd yearned to become a hematologist like Bob Bird. But on his preceptorship he noticed that for every hematology problem there seemed to be thirty cardiology problems. He looked into cardiology briefly, finally concluding, "you'd practically have to be an electrical engineer to practice cardiology." He opted for medicine and during his first year of residency, found he had a real knack for treating asthmatics, especially the toughest and most refractory cases.

The chief of the allergy and immunology section also noticed Floyd's knack and asked if he would like to do a one-year fellowship. He would join seven or eight other fellows and six full-time faculty in what was reputed as one of the two top programs in the nation. Honored and interested, Floyd said yes and began four months of research and eight months of clinical work, treating the most severe asthmatics and comforting the families of those who succumbed. He also learned through participating in the Tecumseh (epidemiological) Study that two widely circulated allergy truisms were absurd myths: 1.) that African Americans almost never suffer from allergic diseases; and 2.) 50% of hay fever sufferers develop asthma.

After completing the fellowship, Floyd moved his family to San Antonio for two years, courtesy of the US Air Force. He was instantly transformed from a fellow into the third-ranking allergy consultant for the Air Force worldwide. His most renowned patients, however, all came from a mere 195 miles away in Houston.

They were the original seven Mercury astronauts. Miller was attracted to Alan Shepherd most of all. "If I were in a foxhole, I'd want Al with me. If I wanted to debate the enemy, I'd take John Glenn," Miller deadpans. He and other Air Force physicians were aware that four of the seven astronauts had medical conditions that could have gotten them grounded, including Gus Grissom, who had "severe allergic nasal disease." Only Deke Slayton was ever grounded (in his case, for a heart murmur).



Dr. Miller reviews the day's schedule with employee Jeannie Hooper. "He still wants to be of service," says long-time friend and fellow physician Dr. Ted Brickner.

A person with Miller's credentials could have practiced just about anywhere he wanted. Oddly, he didn't choose Tulsa so much as he was recruited to it by Dr. Manual Brown, who was the second allergist to practice in the city. "I had put out the word that I was looking for a top-notch allergist and had already turned down several candidates," Brown recalls. "When I met Floyd at a national allergy meeting, I'd already heard from his chief at Ann Arbor that he was the brightest resident he'd ever had. We hit it off right away and struck up a deal."

But first Miller owed the Air Force two years. Just before he was discharged, he received an offer to take over the allergy and immunology service at Ann Arbor—quite a plumb position. This presented a distinct Y in the road. Had he taken the academic job, Miller would have broken his commitment to Dr. Brown who had been waiting for him to complete his military service for the last two years. Instead, Miller joined Dr. Brown in Tulsa, remaining partners for 36 years until Dr. Brown's retirement last year. During that time, Brown says, "we had one, ONE, serious argument and it turned out to be a misunderstanding that blew over in a day or two." While the partners will admit to not agreeing about everything, they both say that the best thing about their partnership was the privilege of knowing one another.

When Miller established his allergy practice in 1963 he was, according to long-time Tulsa internist C.S. Lewis, the first Tulsa internist to restrict his practice to a subspecialty. Though he was busy from the first, his daily activities included driving to Tulsa's three major hospitals—Hillcrest, Saint John, and St. Francis—where he might see only one or two patients per hospital. And for many years he made house calls to see his asthma patients through crises. He used the few medicines of the day (ephedrine, adrenaline, theophylline) and then just sat, waiting and hoping for improvement. Often he would remain for hours until the patient was out of danger. "I ate many a holiday meal with families while waiting out an asthma attack. If the patient didn't respond, I'd drive him or her to the hospital in my car," Miller says.

Today's medicines are so much better, he says, that virtually no asthmatic should die from the disease. The "vast majority" of his asthma patients have their disease under control and have never been admitted to a hospital or visited an ER as the result of an attack.

So the question becomes: why are both the number of cases and the mortality rate of asthma increasing? If Cook County (Chicago), Harlem (New York), and Watts (Los Angeles) are not counted, the death rate falls significantly, Miller says. Allergy-induced asthmatics make up half the total; if they are living in poverty and exposed to potent asthma producers like mites and cockroaches, they will have more frequent and severe attacks. And any chronic asthmatic lacking access to adequate medical care is in peril. These individuals peri-

odically turn up in an ER, wheezing and gasping for breath, only to spend days or weeks in the hospital in the beginning of what often becomes a downward spiral.

One explanation for the increase in the incidence of asthma is particularly vexing to Miller. Many stories reported by the media imply that stress and unhappiness bring on asthma attacks. While Miller agrees that too much stress can induce or exacerbate an attack, he says this angle is so overemphasized that, "it's pathetic. In the overwhelming number of cases, it's not being able to breathe that brings on the stress, not vice versa. Psychosomatic asthmas are interesting and popular, but rare—maybe 5% of the total."

As with asthma, new medicines have also greatly improved the treatment of the so-called hay fever sufferers. "Years ago, we used to give injections to hyposensitize patients in an almost scattergun way. Today 85% of pollen-sensitive patients should get a response to injections, which are now standardized; with mold, 65%; house dust and mites, 85% to 90%. Injections get a bad name because so many people are taking them inappropriately," Miller says. "They come in with a stuffy nose, test positive, and are put on shots. They respond right away, probably due to the placebo effect, then fall off when it should be the opposite."



Through the 1960s, Miller attended county and state medical meetings and came to the attention of OSMA president Ed Calhoon, MD, who asked him to chair the annual meeting in 1970. Three years later, Miller was elected president of the Tulsa County Medical Society. He says he wound up the year temporarily "burned out," having put in too much time on Tulsa issues that either added more hours to his already overcrowded schedule, or took time away from his practice and volunteer work of staffing a free clinic at Hillcrest one morning a week.

Of those issues, two stand out in his memory. One involved recognizing and illuminating the fact that many Tulsans' main barrier to adequate health care was transportation. In response, the Tulsa county president suggested to the city council a transportation subsidy to allow the needy and disabled to get to and from doctor's appointments. He recalls "making some headway" on the issue.

Another issue he recalls seems quaint in this day and age. In 1973, medicine had a strict ethic against physician advertising—which extended in the minds of many to include a prohibition against a doctor's name appearing as an expert source in a news story. Miller and the majority of Tulsa county members supported that ethic. Representing Tulsa physicians, Miller debated Clayton Vaughn, a local television anchor, in a public forum. "I told Mr. Vaughn that we wouldn't object to our names being used if he would stop quoting 'unnamed sources,' which as an old newspaperman I had never liked."

They agreed to disagree until the Federal Trade Commission ruled that professional ethics against advertising constituted restraint of trade. "You can see the result in the Yellow Pages today," Miller says, "and that is exactly what we didn't want to happen."

As OSMA president, Miller dealt with the issue again in his 1980-1981 term. "On one of our trips to Washington, the Justice Department told David Bickham [former OSMA executive director] and me that they wanted a list of approved prices for medical services. Over at the FTC, they told us if we did that, they would sue us for anti-trust violations. We decided to do nothing and fortunately Justice wasn't heard from again."

From 1983 to 1990, Miller was part of a talented and capable group of state leaders elected to the AMA House of Delegates. He and others such as Perry Lambird, Orange Welborn, Joe Crosthwait, Ed Calhoon, and Mike Haugh made several trips to Washington to lobby members of the congressional delegation. Years later, the issues they addressed don't endure in his memory in the same way as the personalities of the participants. Miller says the group that represented OSMA, while small, was probably the best organized of them all. Though the Oklahoma delegation had some successes and failures in Washington, "there is no question we had a moderating influence on the AMA, which had been too far to the right to be effective." Among the group, Floyd was known as an adept conciliator, no small feat given the issues, politics, and egos involved.

He could pull this off, according to his good friend and long-time golfing partner Dr. Ted Brickner, because "he had all the right qualities. Everybody knows he is honest and dedicated to doing the right thing. And the only person I've seen who could work a room better than Floyd was David Boren."

Occasionally, he took more forceful stands. Brickner witnessed one at a medical meeting held at Shangra-la several years ago. "Floyd had this OU provost or dean backed into a corner and was reading him the riot act. This guy had been trying to put together a university-based managed care organization that would have excluded Oklahoma City and Tulsa private practitioners. Floyd concluded this chewing out by saying he was going to run him out of Oklahoma. The remarkable thing was while this 'meeting' was confrontational, Floyd didn't seem angry—no swearing or wild gestures, you know. He was just telling the man what he needed to know. Getting in the man's face certainly wasn't standard operating procedure for Floyd, but I have to tell you that the man in question was gone within six months."

Manuel Brown and Ted Brickner agree that Floyd Miller's greatest accomplishment in his thirty-plus years of service to organized medicine was playing a major role in the development of PLICO, the Physicians Liability Insurance Company, in 1979. Miller agrees as well. The impetus for PLICO came in the late 1970s when several sizeable malpractice payouts caused insurance companies to flee the state. OSMA borrowed $1 million to capitalize PLICO and shield Oklahoma physicians from what became a malpractice insurance crisis. As president-elect of the OSMA, Miller was named to the PLICO board, a position only he and Ed Calhoon have held from the beginning. Miller has chaired the board since 1996. "Physicians who've been in practice in Oklahoma for 20 years or more really appreciate what we've done for them. The younger ones probably have no idea."

One reason Miller has stayed on the PLICO board so long is that he enjoys the camaraderie at the meetings. "You don't see such closeness among physicians much anymore. It reminds me of my early days of practice when doctors were friends and worked together."

Staying on the board might also be a factor in why Miller, at age 70, is not entertaining serious notions of retiring. Some doctors believe that only practicing physicians should serve on such board. But Manuel Brown offers another reason: "I think he would miss his patients, but I think the main reason he keeps his office open is out of loyalty to his office staff." Brickner seconds that opinion, though he concedes that Miller's office staff could undoubtedly secure employment elsewhere. "I play golf and shoot the bull with Floyd and Mike Haugh every week, and I think I can say that he still wants to be of service. That's why guys like us got into medicine in the first place."



In addition to his practice, Dr. Miller chairs the Physicians' Liability Insurance Company board — but he still finds time for an occasional round of golf. Pictured are Dr. Miller and Southern Hills golf pro Dave Bryan.

What all this seems to add up to is a life in balance. Miller is content with the niche he's carved for himself as he enters his eighth decade, but he also knows that changes are in the offing. Last year he had a laminectomy and was quite unhappy when he couldn't play golf during his convalescence. But he says he bounced back "as awkward as ever." At age 75, a mandatory loss of hospital privileges will kick in.

That gives him five years to figure out what to do next.

Doctor's Diary

Thoughts Upon Joy

Hannah A. Saadah, MD

We live for joy, for without joy, life darkens.
Joy is our creed and life, our struggle.
Our struggle for joy is what puts joy in our struggle.
Wherever joy lies, we tend
For joy is our obsession
And its nature, our illusion.

We believe that joy lies in sundry pursuits:
knowledge, power, success, glory
pleasure, beauty, art, creativity
health, security, plenty
faith, unity, ideals, heroism
serving, giving, loving, sacrificing
wisdom, contentment, reason, etc.
but, no two share identical beliefs.

Indeed, we all have individual illusions
Colored by our lives' experiences.
We are whom we believe we are
And our illusions represent our personal realities.
Everything we are and do is reasonable to us
For we all have our particular reasons.
Conflicts arise when we are unable to understand
Or unwilling to empathize
With each other's illusions and reasons.

Our hungers are our wings and our fears, our cages.
They are the life forces within us which we
Do not choose though they direct our course.
Hungers drive our passions and fears, our inhibitions.
Between these two mighty rudders
We sail through life on our quest for joy.

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A Most Memorable Christmas

J.D. Haines, MD

My most memorable Christmas was not in the familiar snow-covered Oklahoma hills that I love so well. It was on another continent, deep in the Sahara Desert, when I was fifteen years old. My family lived in Tripoli, Libya, where my father worked in the oil business. A tight-knit community of 5,000 Americans and the nearby Wheelus Air Force Base were our links to home, especially during the holidays.

During the Christmas season of 1970, there were still a lot of uncertainties in Libya. We had survived Colonel Qaddafi's revolution, but Wheelus Air Force Base had been forced to close. Qaddafi's antagonism towards Westerners made life difficult for everyone. On this particular Christmas, my father was scheduled to work in the desert over the holidays.

In years past, the oil companies flew families to the desert oil camps to reunite them for the holidays. There was real concern whether the Libyan government would allow the flights, but to our delight they were finally approved.

As I peered out the window of the plane high over the Sahara, I remember how the sand dunes seemed like waves on a vast ocean. Our destination was Gialo Oasis, where my father's camp was located. Gialo reminded me of a small military base with barracks, a mess hall, bar, motor pool, air strip, and other facilities.

Besides the obvious thrill of the entire family being together, the oasis was an exciting place to explore. We enjoyed a huge Christmas feast with all the usual trimmings, but the highlight for me was an ice cream machine. Ice cream machines were still a novelty back in 1970, and having unlimited access to one seemed too good to be true. As I was filling a generous-sized bowl, somehow the on/off lever became jammed. As the ice cream mounted higher and higher in my bowl I frantically attempted to turn the machine off. Finally one of my father's friends saw my plight and came to the rescue. I took a lot of good-natured kidding over the mountain of ice cream piled in my bowl.

Aside from Christmas dinner, the highlight of our trip was an excursion by air to the site of the crash of a World War II Liberator Bomber. The story of the Lady Be Good was one of the most tragic mysteries of WWII. In April 1943, an inexperienced young bomber crew flew its maiden mission from Libya to Italy and vanished on the return flight.

Sixteen years later, the mystery was finally solved. The Lady Be Good had become separated from her bomber group and became lost during the nighttime return flight. The crew believed they were over the Mediterranean when they were flying deeper into the Sahara.

When the fuel finally ran out, the Lady Be Good crash landed more than 500 miles from the coast. With just several half-canteens of water and practically no food, the crew began walking toward the coast, hoping it was just a few miles distant. The last crew member collapsed and died 115 miles from the wreckage. Search missions failed to consider that the bomber could have strayed so far from its base in Benghazi. Sixteen long years would pass before an oil field exploration crew solved the mystery.

When our pilot spotted the crash, we landed on the hard-packed sand nearby. The dry desert air had preserved the wreckage remarkably well. As I scanned the desolate horizon in every direction, I realized how truly lost those brave airmen must have felt.

A stained glass window in the Wheelus Air Force Base Chapel memorialized the crew of the Lady Be Good. I will always remember the inscription; it read, "In memory of nine who made the desert a highway for our God. Anno Domini 1943. Lord guard and guide the men who fly." Christmas has reminded me ever since of the tremendous debt America owes its soldiers, sailors, and airmen who fought and died to give us the gift of freedom.



News

Polio Alert

A current outbreak of poliomyelitis in Dominican Republic and Haiti has raised serious concerns about the risk to United States citizens. Because of the close proximity to the United States and frequent travel between these countries and the US, the Oklahoma State Department of Health is alerting physicians to the outbreak. The key factor for minimizing the risk of polio among Oklahoma children is to maintain high vaccination coverage. Oklahoma physicians are urged to ensure that their patients are adequately immunized with four doses of IPV.

Travelers of any age to the Dominican Republic and Haiti who are not adequately immunized must be considered at risk of acquiring poliomyelitis, and should be fully immunized before travel.

The diagnosis of poliomyelitis should be considered in all patients who present with acute flaccid paralysis, especially those who have traveled to or have been exposed to persons who have traveled to the Dominican Republic or Haiti. If poliomyelitis is suspected, please call the Immunization Division, Maternal and Child Health Service, Oklahoma State Department of Health, at 405/271-4073 immediately.

Ziegler Named to Cancer Liaison Program

James Ziegler, MD, of Lawton, recently received a three-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at Southwestern Medical Center as part of the Commission on Cancer of the American College of Surgeons. Dr. Ziegler joins a national network of more than 1,800 volunteer Cancer Liaison Physicians who provide leadership and support to the Approvals Program and other Commission on Cancer activities.

Vannatta Nominated for Humanism in Medicine Award

Jerry Vannatta, MD, dean of the University of Oklahoma College of Medicine, was recently recognized as a nominee for the Humanism in Medicine Award presented by the Association of American Medical Colleges (AAMC). Dr. Vannatta was one of only 47 physicians nationwide to receive a nomination; he was nominated by OU medical students. The award annually honors medical school faculty physicians who embody the finest qualities in a physician who teaches healing.

AMA Interim Meeting Concludes

The 2000 Interim Meeting of the American Medical Association was held December 3-6, 2000, in Orlando, Florida. During the meeting, Delegates considered several reports and resolutions in various reference committee meetings, including the report of the Commission on Unity, adopted as amended by Reference Committee F, that requested endorsement of the commission's concept of the idealized design for the future structure of the Federation of medicine and provides the foundation for developing an implementation plan.

Of particular interest to the national media and the public at large was the announcement by the AMA that it had approved recommendations regarding greater access to emergency contraception pills. In a statement released by the AMA, Edward J. Hill, MD, AMA trustee announced, "...In addition to reaffirming current AMA policy that holds that no physician or other professional personnel should be required to perform an act that violates personally held moral principles, the AMA passed new policies to encourage physicians to play an more active role in providing education about access to ECPs. The new policies also direct the AMA to intensify efforts to improve awareness and understanding about the drugs and to enhance efforts to expand access to them, including making them more available through hospitals, clinics, emergency rooms, acute care centers, and physicians' offices. In order to expand access to ECPs, the AMA also decided to support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA). If the FDA determines that ECPs are safe for over-the-counter use, the AMA would support that increased access."

2000 Index
Volume 93, Numbers 1-12

Index to Pages

1-40	January
41-84	February
85-136	March
137-180	April
181-224	May
225-264	June
265-384	July
385-428	August
429-468	September
469-512	October
513-544	November
545-596	December

Cover Photos:

April 2000
William Harrison, MD, Chickasha

July 2000
Robert Smith, MD, Oklahoma City

August 2000
Robert Smith, MD, Oklahoma City

September 2000
Robert Smith, MD, Oklahoma City

November 2000
Ray V. McIntyre, MD, Kingfisher

The Author Index is in a separate section following the Subject Index.

Subject Index

A

alcohol
Alcohal Consumption Amang the Elderly: Dispelling the Myths. Tivis LJ, Brandt EN, 275

ALLIANCE
39, 86, 135, 179, 223, 263, 383, 427, 467, 511, 543, 591

ANNUAL MEETING
94th Annual Meeting Schedule, Registratian, 123
Resalutians af the 2000 OSMA Annual Meeting, 414
2000 Annual Meeting Praceedings, 289

B

bioterrorism
Medical Respanse ta Biaterrarism: Are We Prepared? Haines JD, Pitts K, Crutcher JM, 187

C

carpal tunnel syndrome
Preventing Carpal Tunnel Syndrame and Cumulative Trauma Disarder: Effect af Carpal Tunnel Decampressian Exercises: An Oklahama Experience. Seradge H, Baer C, Bithell D, 150

chest pain
61-Year-Old Man with Midsternal Chest Pain, Mid-Back Pain, and Lawer Extremity Weakness: A Clinicapathalagic Carrelatian Canference fram the University af Oklahama College af Medicine. Kida M, Sivaram CA, Bahu N, Walter M, 231

child abuse
State Health Agency Pramates "Safe at Hame" far Child Abuse Preventian Manth. Dauglas MR, Gehue C, 167

CLASSIFIEDS
77, 128, 174, 257, 259, 378, 423, 463, 507, 537, 590

clinicopathologic correlation conference
A Cardiac Patient with Renal Failure: A Clinicapathalagic Carrelatian Canference fram the University af Oklahama College af Medicine. Sauthmayd L, Eatan BG, Kaufman C, Silva FG, 11
61-Year-Old Man with Midsternal Chest Pain, Mid-Back Pain, and Lawer Extremity Weakness: A Clinicapathalagic Carrelatian Canference from the University af Oklahama College af Medicine. Kida M, Sivaram CA, Bahu N, Walter M, 231

COMMENTARY
Drug Seeking Behaviar–A Differential Appraach. Yarbaraugh WH, 242
The State of the State of the State's Health Repart. Dewberry GP, 528

CONNECTED CLINICIAN
The Ecanamy af Medical Knawledge. Candler C, 70
Medschaol.cam: Oppartunity ar Threat? Candler C, 287

CONTINUING MEDICAL EDUCATION
35, 67, 129, 175, 219, 262, 382, 426, 466, 510, 542, 592, 593

credentialing
Unifarm Credentialing Application–Here At Last! Seba M, 132

curriculum
A Curriculum far Stimulating the Maral Imaginatian. Vannatta JB, Schleifer R, 63

D

DEATHS/OBITUARIES
Andersan, Hubert M, MD, 379
Barney, Danald Charles, MD, 127
Blevins, Billy E, MD, 217
Braly, Alan Knight, MD, 76
Chatham, Beverly Calvin, MD, 76
Cheek, William Clark, MD, 34
Callins, Jae E, MD, 589
Caak Jr., Charles E, MD, 127
Caaper, Charles L, MD, 590
Cotner, Narman A, MD, 76
DeBiase, Jahn Rabert, MD, 34
Demas, Rass P, MD, 379
Deupree, Harry L, MD, 127
Elliat, Arthur F, MD, 539
Elrad, Bill B, MD, 34
First, Safety R, MD, 590
Glasgaw, Jack G, MD, 423
Gorrell, Benjamin F, MD, 259
Gray Jr., John F., MD, 539
Greer, Allen E, MD, 34
Harrisan, Lynn H, MD, 127
Haffman, Kenneth C, MD, 127
Hallingswarth, Francis W, MD, 589
Hardinsky, Jerry R, MD, 539
Harne, Malcalm, MD, 76
Huntingtan, Camp S, MD, 507
Jahnsan, Danald E, MD, 34
Janes, Bab, 127
Kell, Thornton, MD, 539
Lawsan, Ray A, MD, 259
Leman, Willis E, MD, 259
Llewellyn III, Thamas S, MD, 76
McCreight Sr., William G, MD, 173
McDaniel, Jahn Prestan, MD, 76
McDawell, Richard E, MD, 127
McInnis, James Therman, MD, 76
Meece, Leo, MD 173
Mershan, Helen Ruth, MD, 589
Nichalsan, James L, MD, 173
Narberg, Hans Peter Franz, MD, 539
Parsans Orval L, MD, 173
Palk, Dauglas Lyans, MD, 76
Recards, Jahn W, MD, 590
Raark, Wilson E, MD, 423
Ruprecht, Hamer A, MD, 173
Smith Jr, Geargе R, MD, 589
Start, Armand H, MD, 217
Steen, Wilsan David, PhD, 76
Stone, William C, MD, 379
Tyler, Joe Earle, MD, 76
Vammen, Adolph N, MD, 259
Weedn, Jaseph D, MD, 507
Wiggins, Everett L, MD, 539
White, James William, MD, 173
Yaun, Hwan X., MD, 76

diabetes
Screening far Gestatianal Diabetes: An Evidence-Based Appraach. Clemensan ND, 197

DOCTOR'S DIARY
The Fabric af Oklahama Medicine. Haines JD, 72
The Nadule. Daugherty RJ, 411
Thaughts Upan Jay. Saadah HA, 578
Vialence in Perspective. Haines JD, 210

drug-seeking behavior
Drug Seeking Behaviar—A Differential Appraach. Yarbaraugh WH, 242

E

EDITORIAL
Awakenings....Pantiaus JM, 183
A Century af Naurishment. Pantiaus JM, 471
Cynicism and Strawberries. Pantiaus JM, 227
A Deunified Unificatian? Pantiaus JM, 87
Far Unta Us is Barn. Pantiaus JM, 547
It's Nat Our Fault.... Pantiaus JM, 3
Much is Required....Pantiaus JM, 387
On Demacracy. Pantiaus JM, 267
On Healthcare Fraud.... Pantiaus JM, 515
The Pause....Pantiaus JM, 43
Remembering September. Pantiaus JM, 431
The Wisdam of a Rural Path. Pantiaus JM, 139

EDUCATION
Medical Respanse ta Biaterrarism: Are We Prepared? Haines JD, Pitts K, Crutcher JM, 187

educational technology
Medschaal.cam: Opportunity ar Threat? Candler C, 287

F

Floyd Miller, MD
Flayd Miller, MD. Green R, 569

folic acid
Falic Acid Knawledge and Multivitamin Use Amang Oklahama Wamen. Mantgamery J, Pearan K, Thamas W, Rhaades E, Larenz D, 256

FROM OSMA LEGAL COUNSEL
American Saciety af Medical Assaciatian Caunsel Addresses OIG Draft Campliance Guidance, Litigatian Against MCOs. Scaggins L, 461

FROM THE OSDH
Falic Acid Knawledge and Multivitamin Use Amang Oklahama Wamen. Mantgamery J, Pearan K, Thamas W, Rhaades E, Larenz D, 256
Intimate Partner Vialence. Brawn S, Smith-Edwards C, 505
It's That Time—Back ta Schaal! 419
Reducing Teen Pregnancy in Oklahama: Facusing an Older Teens (18-19 Years Old). Lanphier M, Radine S, 214
SIDS in Oklahama: Is the "Back ta Sleep" Message Reaching Everyane? Byerly P, Patrick P, 535

fungi
Isalatian af Fungi Fram Rase Bush Tharns. Flaurnay DJ, Mullins JB, McNeal RJ, 271

H

health plans survey
Cansumer Assessment af Health Plans Survey (CAHPS®) Results far Oklahama Managed Care Medicaid: 1997, 1998, and 1999. Millar JS, McCauley D, Hays C, Winstan T, Mitchell L, 109

HOLIDAY MEMORIES
579

I

immunization
Immunization Rate Comparison for Oklahoma Medicaid Managed Care Population by Age Two: 1995-1998. Millar JS, McCauley D, Mitchell L, Winston T, Hays C, 20
It's That Time–Back to School! 419

investment policy
New Investment Policy for the Oklahoma State Medical Association. Beller, JJ, 47

IN MEMORIAM
34, 77, 128, 173, 217, 259, 379, 423, 463, 507, 539, 589

J

Jolly West
The Early Years: Jolly West and the University of Oklahoma Department of Psychiatry. Green R, 446

L

LAST WORD
40, 84, 136, 180, 224, 264, 384, 428, 468, 512, 544, 596

LEADERS IN MEDICINE
Floyd Miller, MD. Green R, 569
Myra A. Peters, MD: The Steel Magnolia. Green R, 93

LETTERS TO THE EDITOR
171, 218, 257, 462, 537

LITERATURE AND MEDICINE
A Curriculum for Stimulating the Moral Imagination. Vannatta JB, Schleifer R, 63

M

Medicaid
Consumer Assessment of Health Plans Survey (CAHPS®) Results for Oklahoma Managed Care Medicaid: 1997, 1998, and 1999. Millar JS, McCauley D, Hays C, Winston T, Mitchell L, 109
Immunization Rate Comparison for Oklahoma Medicaid Managed Care Population by Age Two: 1995-1998. Millar JS, McCauley D, Mitchell L, Winston T, Hays C, 20

medical knowledge
The Economy of Medical Knowledge. Candler C, 70
Myra A. Peters, MD
Myra A. Peters, MD: The Steel Magnolia. Green R, 93

N

NEWS
Alzheimer's Report Available, 75
AMA Alliance Notes March Health Observations, 122
AMA Interim Meeting Concludes, 580
AMA Sets Leadership Conference, 74
Area Physicians Announce Community Service Projects, 169
Brandt to be Honored at "Evening of Excellence," 29
Brumback Establishes Endowed Professor in Honor of Revolutionary War Ancestor, 503
Calhoon Named OAFP Family Physician of the Year, 375
CDC Calls for Prevention Measures for Patients with Diabetes, 31
CDC Influenza Vaccine Recommendations for 2000-2001 Influenza Season Only, 504
Celebrating Women in Medicine Month, 459
Dextromethorphan Abuse on the Rise in Oklahoma, 213
Domestic Terrorism Exercise Held in Oklahoma City, 418
Eaton Named Physician of the Year by OU Medical Alumni Association, 417
Influenza Vaccine Supply Delays, Shortages Expected, 504
Informational Tour Takes Physicians' Campaign for a Healthier Oklahoma to County Medical Societies, 122
In Memoriam: Brenda F. Hays, 503
"Jawbones" and "Sawbones" Tee It Up for Charity, 375
Mowry, Moran Receive Presidential Citations, 531
News Briefs, 121
New Standards Recommended for Women's Health Screening, 75
Oklahoma City Physicians Headed to Sydney, 459
Oklahoma Physician Named to Cancer Liaison Program, 375
Oklahoma Physician Promoted to Brigadier General, 211
Oklahoma Physicians Honored by the University of Oklahoma College of Medicine, 374
Oklahoma Physicians Recognized for Contributions to Mental Health, 211
Oklahoma Scientists Conducting Groundbreaking Research on Alzheimer's Disease, 211
Organ Sharing Network Proposes Definition of Imminent Death, 170
OSMA Convenes 94th Annual Meeting at The Westin in Oklahoma City, 254
OSMA Delegates and Members Attend AMA Interim Meeting, 29
OSMA Leaders Emphasize Significance of Health Report at Briefing, 121
OSMA Medicine Day at the Capitol, 212
OSMA Seminars Focus on the Evolving Needs of the Health Care Community, 30
OSMA Web Site Offers Password Protection, 417
OU Develops Computer Training for Physicians, 74
Paddack Takes Office as National President, 253
Paddack's 2000-2001 Presidential Agenda, 253
Pelofsky to Lead National Association, 253
Phillips Named to Cancer Care Post, 74
Polio Alert, 580
Public Health Excellence Awards Given, 531
Resident Award to be Established in Memory of Perry Lambird, MD, 169
Summer Fun at the Bricktown Ballpark! 460
Update: Continuing Medical Education and Your Oklahoma License Renewal, 532
Vannatta Nominated for Humanism in Medicine Award, 580
Video Conference on Asthma Management Planned, 75

Woods Named to Physician Monpower Training Post, 417
Ziegler Named to Cancer Liaison Program, 580
Zingarelli Appointed Cancer Liaison Physician, 169

O

OBITUARIES/DEATHS

Anderson, Hubert M, MD, 379
Barney, Donald Charles, MD, 127
Blevins, Billy E, MD, 217
Braly, Alan Knight, MD, 76
Chatham, Beverly Colvin, MD, 76
Cheek, William Clark, MD, 34
Collins, Joe E, MD, 589
Cook Jr., Charles E, MD, 127
Cooper, Charles L, MD, 590
Cotner, Norman A, MD, 76
DeBiase, John Robert, MD, 34
Demas, Ross P, MD, 379
Deupree, Harry L, MD, 127
Elliot, Arthur F, MD, 539
Elrod, Bill B, MD, 34
First, Safety R, MD, 590
Glasgaw, Jack G, MD, 423
Gorrell, Benjamin F, MD, 259
Gray Jr., John F., MD, 539
Greer, Allen E, MD, 34
Harrison, Lynn H, MD, 127
Hoffman, Kenneth C, MD, 127
Hollingsworth, Francis W, MD, 589
Hordinsky, Jerry R, MD, 539
Horne, Malcolm, MD, 76
Huntington, Camp S, MD, 507
Johnson, Donald E, MD, 34
Jones, Bob, 127
Kell, Thornton, MD, 539
Lawson, Roy A, MD, 259
Lemon, Willis E, MD, 259
Llewellyn III, Thomas S, MD, 76
McCreight Sr., William G, MD, 173
McDaniel, John Preston, MD, 76
McDowell, Richard E, MD, 127
McInnis, James Thermon, MD, 76
Meece, Leo, MD 173
Mershon, Helen Ruth, MD, 589
Nicholson, James L, MD, 173
Narberg, Hans Peter Franz, MD, 539
Parsons Orval L, MD, 173
Polk, Douglas Lyons, MD, 76
Records, John W, MD, 590
Roark, Wilson E, MD, 423
Ruprecht, Homer A, MD, 173
Smith Jr, George R, MD, 589
Start, Armond H, MD, 217
Steen, Wilson David, PhD, 76
Stone, William C, MD, 379
Tyler, Joe Earle, MD, 76
Vammen, Adolph N, MD, 259
Weedn, Joseph D, MD, 507
Wiggins, Everett L, MD, 539
White, James William, MD, 173
Youn, Hwan X., MD, 76

OIG Compliance Guidance

American Society of Medical Association Counsel Addresses OIG Draft Compliance Guidance, Litigation Against MCOs. Scoggins L, 461

Oklahoma medicine

Caring for Oklahoma's Children: The Department of Pediatrics and Children's Hospital of Oklahoma. Rettig SS, Stull TL, 489
The Early Years: Jolly West and the University of Oklahoma Department of Psychiatry. Green R, 446
The Fabric of Oklahoma Medicine. Haines JD, 72
Full-Time Clinical Department Chairs: Time of Transition. Andrews MD, 493
The History of Electrocardiology ond Electrophysiology at the University of Oklahoma. Lazzara R, 486
A History of the University of Oklahoma College of Medicine: Perspectives on Funding the Educational Mission. Vannatta JB, 475
Medical College Deans at Critical Stages. Brandt EN, 483
The Oklahoma Repair Technique: A Biomechanical Study of a New Suture Repair Technique. Seradge H, Tian W, Kashef GH, Seradge A, Owen W, 551
An Overview of Women Seeking Substance Abuse Treatment in Oklahoma. Trautman RP, Phillips ME, Hallford G, Borrell GK, Nixon SJ, 437
Preventing Carpol Tunnel Syndrome and Cumulotive Trauma Disorder: Effect of Carpal Tunnel Decompression Exercises: An Oklahoma Experience. Seradge H, Baer C, Bithell D, 150

ozone exposure

Ozone Exposure: A Case Report and Discussion. Parks S, Paul DW, 48

P

PATIENT HANDOUT

10, 61, 107, 159, 209, 251, 285, 409, 444, 501, 526, 567

physicians' rights

AMA Litigation Center Pushes for Physician Rights. Scoggins L, 68

PRACTICE MANAGEMENT

AMA Litigation Center Pushes for Physician Rights. Scoggins L, 68

pregnancy

Reducing Teen Pregnancy in Oklahoma: Focusing on Older Teens (18-19 Years Old). Lanphier M, Rodine S, 214

PRESIDENT'S PAGE

Advocacy, Not Apathy. Weedn RJ, 269
The AMA: Serving Oklahoma Physicians. Weedn RJ, 389
An Alliance of Strength ond Unity. Weedn RJ, 229
A Call to Action. Weedn RJ, 549
Covering the State: The Physicians' Liability Insurance Company. Weedn RJ, 517
Get Active In Your Gavernment. Whitlock BO, 44
The Grass Roots. Whitlock BO, 141
Meeting the Challenge. Weedn RJ, 185
New Work for the New Year. Whitlock BO, 5
SQ 692: Protecting the Health of Oklohomans. Weedn RJ, 473
Welcoming the Next Generation. Weedn RJ, 433
We're Busy Preparing for the Future. Whitlock BO, 90

prevention

An Analysis of Factors Associated with Seat Belt Use: Preventian Opportunities for the Medical Community. Baker DR, Clarke SR, Brandt EN, 496
Improving the Health of Oklahomans Through Clinical Prevention, Part I: Counseling to Decrease Major Risk Factors. DeRose DJ, Crutcher JM, DePersio SR, 52

Improving the Health of Oklahomans Through Clinical Prevention, Part II: Screening to Identify Early-Stage Disease and Risk Factors. Crutcher JM, DeRose DJ, DePersio SR, 397
Improving the Health of Oklahomans Through Clinical Prevention, Part III: Immunizations and Chemoprophylaxis. Crutcher JM, DeRose DJ, DePersio SR, 557
Preventive Care in Daily Practice. Ferguson RS, 154

prostate cancer
Prostate Cancer Treatment with Ultrasound-Guided Transperineal Brachytherapy: Analysis of the Treatment Results of Our First 150 Patients. Larson G, Pappas N, Hossain B, 391

R

renal failure
A Cardiac Patient with Renal Failure: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine. Southmayd L, Eaton BG, Kaufman C, Silva FG, 11

risk factors
Improving the Health of Oklahomans Through Clinical Prevention, Part I: Counseling to Decrease Major Risk Factors. DeRose DJ, Crutcher JM, DePersio SR, 52

rural medicine
Physicians Face Challenges in the Practice of Rural Medicine. Stafford J, 143
Rural Hospitals Provide Much-Needed Patient Care. Stafford J, 148

S

SCIENTIFIC
A Cardiac Patient with Renal Failure: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine. Southmayd L, Eaton BG, Kaufman C, Silva FG, 11
Consumer Assessment of Health Plans Survey (CAHPS®) Results for Oklahoma Managed Care Medicaid: 1997, 1998, and 1999. Miller JS, McCauley D, Hays C, Winston T, Mitchell L, 109
Immunization Rate Comparison for Oklahoma Medicaid Managed Care Population by Age Two: 1995-1998. Miller JS, McCauley D, Mitchell L, Winston T, Hays C, 20
Improving the Health of Oklahomans Through Clinical Prevention, Part II: Screening to Identify Early-Stage Disease and Risk Factors. Crutcher JM, DeRose DJ, DePersio SR, 397
Isolation of Fungi From Rose Bush Thorns. Flournoy DJ, Mullins JB, McNeal RJ, 271
Occult Quinine-Induced Thrombocytopenia. Kajouri K, Perdue JJ, Medina PJ, George JN, 519
The Oklahoma Repair Technique: A Biomechanical Study of a New Suture Repair Technique. Serodge H, Tian W, Koshef GH, Serodge A, Owen W, 551
Ozone Exposure: A Case Report and Discussion. Parks S, Paul DW, 48
Preventing Carpal Tunnel Syndrome and Cumulative Trauma Disorder: Effect of Carpal Tunnel Decompression Exercises: An Oklahoma Experience. Serodge H, Baer C, Bithell D, 150
Prostate Cancer Treatment with Ultrasound-Guided Transperineal Brachytherapy: Analysis of the Treatment Results of Our First 150 Patients. Larson G, Pappas N, Hossain B, 391
Screening for Gestational Diabetes: An Evidence-Based Approach. Clemenson ND, 197
Severe Invasive Group A Beta-Hemolytic Streptococcus Infection Complicating Pharyngitis: A Case Report and Discussion. Kelly SB, Dick L, 25
61-Year-Old Man with Midsternal Chest Pain, Mid-Back Pain, and Lower Extremity Weakness: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine. Kida M, Sivaram CA, Bahu N, Walter M, 231
Thumb Digital Neuropathy Caused By Splinting. Kagel EM, Rayon GM, 435

seat belts
An Analysis of Factors Associated with Seat Belt Use: Prevention Opportunities for the Medical Community. Baker DR, Clarke SR, Brandt EN, 496

smoking
Do Physicians Counsel Smokers to Quit? Mahan MA, 103
Effects of Smoking on Health Care Costs. Nair AK, Brandt EN, 245
The Nodule. Dougherty RJ, 411
Smoking Cessation Overview. Lee SK, Levin DC, McCaffree R, 203

splinting
Thumb Digital Neuropathy Caused By Splinting. Kagel EM, Rayon GM, 435

streptococcus
Severe Invasive Group A Beta-Hemolytic Streptococcus Infection Complicating Pharyngitis: A Case Report and Discussion. Kelly SB, Dick L, 25

sudden infant death syndrome (SIDS)
SIDS in Oklahoma: Is the "Back to Sleep" Message Reaching Everyone? Byerly P, Patrick P, 535

suture
The Oklahoma Repair Technique: A Biomechanical Study of a New Suture Repair Technique. Serodge H, Tian W, Koshef GH, Serodge A, Owen W, 551

SPECIAL
Alcahal Cansumptian Among the Elderly: Dispelling the Myths. Tivis LJ, Brandt EN, 275
An Analysis af Factars Assaciated with Seat Belt Use: Preventian Oppartunities far the Medical Cammunity. Baker DR, Clarke SR, Brandt EN, 496
Caring far Oklahoma's Children: The Department af Pediatrics and Children's Haspital af Oklahama. Rettig SS, Stull TL, 489
Da Physicians Caunsel Smakers ta Quit? Mahan MA, 103
The Early Years: Jally West and the University af Oklahama Department af Psychiatry. Green R, 446
Effects af Smaking an Health Care Casts. Nair AK, Brandt EN, 245
Full-Time Clinical Department Chairs: Time af Transitian. Andrews MD, 493
The Histary af Electracardialagy and Electraphysialagy at the University af Oklahama. Lazzara R, 486
A Histary af the University of Oklahama College of Medicine: Perspectives an Funding the Educational Missian. Vannatta JB, 475
Impraving the Health af Oklahamans Thraugh Clinical Preventian, Part I: Caunseling ta Decrease Majar Risk Factars. DeRase DJ, Crutcher JM, DePersia, SR, 52
Impraving the Health af Oklahamans Thraugh Clinical Preventian, Part III: Immunizatians and Chemapraphylaxis. Crutcher JM, DeRase DJ, DePersia SR, 557
Medical College Deans at Critical Stages. Brandt EN, 483
New Investment Palicy far the Oklahama State Medical Assaciatian. Beller JJ, 47
OSMA Launches Physicians' Campaign far a Healthier Oklahoma. Weedn RJ, 7
An Overview af Wamen Seeking Substance Abuse Treatment in Oklahama. Trautman RP, Phillips ME, Hallfard G, Barrell GK, Nixan SJ, 437
Physicians Face Challenges in the Practice af Rural Medicine. Staffard J, 143
Preventive Care in Daily Practice. Fergusan RS, 154
Rural Haspitals Pravide Much-Needed Patient Care. Staffard J, 148
Thausands Respond to OSMA Take Care Campaign, 119
Smaking Cessatian Overview. Lee SK, Levin DC, McCaffree R, 203
State Health Agency Pramotes "Safe at Hame" far Child Abuse Preventian Manth. Dauglas MR, Gehue C, 167
State af the State's Health. Oklahama State Board of Health, 161
State of the State's Health: Still an the Decline. Gregary JA, 118
Unifarm Credentialing Applicatian–Here At Last! Seba M, 132
Vialence in Adalescents: Leading Factars, Their Effects, and Passible Preventian. Odutala T, Brandt EN, 522

state of the state's health
State af the State's Health. Oklahama State Board af Health, 161
State af the State's Health: Still an the Decline. Gregory JA, 118
The State af the *State of the State's Health Repart.* Dewberry GP, 528

substance abuse
An Overview af Wamen Seeking Substance Abuse Treatment in Oklahama. Trautman RP, Phillips ME, Hallfard G, Borrell GK, Nixan SJ, 437

T

Take Care
Thausands Respand ta OSMA Take Care Campaign, 119

thrombocytopenia
Occult Quinine-Induced Thrambacytapenia. Kajauri K, Perdue JJ, Medina PJ, Gearge JN, 519

U

University of Oklahoma
Caring far Oklahama's Children: The Department af Pediatrics and Children's Haspital af Oklahoma. Rettig SS, Stull TL, 489
The Early Years: Jally West and the University af Oklahama Department af Psychiatry. Green R, 446
Full-Time Clinical Department Chairs: Time af Transitian. Andrews MD, 493
The History af Electracardialagy and Electraphysialagy at the University af Oklahama. Lazzara R, 486
A History of the University af Oklahama College af Medicine: Perspectives an Funding the Educatianal Missian. Vannatta JB, 475
Medical College Deans at Critical Stages. Brandt EN, 483

V

violence
Intimate Partner Vialence. Brawn S, Smith-Edwards C, 505
Vialence in Adalescents: Leading Factars, Their Effects, and Passible Preventian. Odutala T, Brandt EN, 522
Vialence in Perspective. Haines JD, 210

W

white coat
Welcaming Remarks to the Class af 2004. McAlister D, 458
The White Caat: Symbal af Cammitment. Andrews MD, 455

WORTH REPEATING
Welcaming Remarks ta the Class af 2004. McAlister D, 458
The White Caat: Symbal af Cammitment. Andrews MD, 455

Author Index

A

Andrews MD. Full-Time Clinical Department Chairs: Time of Transition, 493
Andrews MD. The White Coat: Symbol of Commitment, 455

B

Baer C. see Seradge H
Bahu N. see Kida M
Baker DR, Clarke SR, Brandt EN. An Analysis of Factors Associated with Seat Belt Use: Prevention Opportunities for the Medical Community, 496
Beller JJ. New Investment Policy for the Oklahoma State Medical Association, 47
Bithell D. see Seradge H
Barrell GK. see Trautman RP
Brandt EN. Medical College Deans at Critical Stages, 483
Brandt EN. see Baker DR
Brandt EN. see Nair AK
Brandt EN. see Odutola T
Brandt EN. see Tivis LJ
Brown S, Smith-Edwards C. Intimate Partner Violence, 505
Byerly P, Patrick P. SIDS in Oklahoma: Is the "Back to Sleep" Message Reaching Everyone? 535

C

Candler C. The Economy of Medical Knowledge, 70
Candler C. Medschool.com: Opportunity or Threat? 287
Clarke SR. see Baker DR
Clemenson ND. Screening for Gestational Diabetes: An Evidence-Based Approach, 197
Crutcher JM, DeRose DJ, DePersia SR. Improving the Health of Oklahomans Through Clinical Prevention, Part II: Screening to Identify Early-Stage Disease and Risk Factors, 397
Crutcher JM, DeRose DJ, DePersio SR. Improving the Health of Oklahomans Through Clinical Prevention, Part III: Immunizations and Chemoprophylaxis, 557
Crutcher JM. see DeRose DJ
Crutcher JM. see Haines JD

D

DeRose DJ, Crutcher JM, DePersia SR. Improving the Health of Oklahomans Through Clinical Prevention, Part I: Counseling to Decrease Major Risk Factors, 52
DeRose DJ. see Crutcher JM
DePersia SR. see Crutcher JM
DePersia SR. see DeRose DJ
Dewberry GP. The State of the State of the State's Health Report, 528
Dick L. see Kelly SB
Daugherty RJ. The Nodule, 411
Douglas MR, Gehue C. State Health Agency Promotes "Safe at Home" for Child Abuse Prevention Month, 167

E

Eaton BG. see Southmayd L

F

Ferguson RS. Preventive Care in Daily Practice, 154
Flournay DJ, Mullins JB, McNeal RJ. Isolation of Fungi From Rose Bush Thorns, 271

G

Gehue C. see Douglas MR
George JN. see Kajouri K
Green R. The Early Years: Jolly West and the University of Oklahoma Department of Psychiatry, 446
Green R. Floyd Miller, MD, 569
Green R. Myra A. Peters, MD: The Steel Magnolia, 93
Gregory JA. State of the State's Health: Still on the Decline, 118

H

Haines JD. The Fabric of Oklahoma Medicine, 72
Haines JD, Pitts K, Crutcher JM. Medical Response to Bioterrorism: Are We Prepared? 187
Haines JD. Violence in Perspective, 210
Hallford G. see Trautman RP
Hassoun B. see Larson G
Hays C. see Millar JS

K

Kagel EM, Rayon GM. Thumb Digital Neuropathy Caused by Splinting, 435
Kashef GH. see Seradge H
Kaufman C. see Southmayd L
Kelly SB, Dick L. Severe Invasive Group A Beta-Hemolytic Streptococcus Infection Complicating Pharyngitis: A Case Report and Discussion, 25
Kida M, Sivaram CA, Bahu N, Walter M. 61-Year-Old Man with Midsternal Chest Pain, Mid-Back Pain, and Lower Extremity Weakness: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine, 231
Kajouri K, Perdue JJ, Medina PJ, George JM. Occult Quinine-Induced Thrombocytopenia, 519

L

Lanphier M, Radine S. Reducing Teen Pregnancy in Oklahoma: Focusing on Older Teens (18-19 Years Old), 214
Larson G, Pappas N, Hassoun B. Prostate Cancer Treatment with Ultrasound-Guided Transperineal Brachytherapy: Analysis of the Treatment Results of Our First 150 Patients, 391
Lazzara R. The History of Electrocardiology and Electrophysiology at the

University of Oklahoma, 486
Lee SK, Levin DC, McCaffree R. Smoking Cessation Overview, 203
Levin DC. see Lee SK
Lorenz D. see Montgomery J

M

McAlister D. Welcoming Remarks to the Class of 2004, 458
McCaffree R. see Lee SK
McCauley D. see Millar JS
McNeal RJ. see Flournoy DJ
Medina PJ. see Kojouri K
Millar JS, McCauley D, Hays C, Winstan T, Mitchell L. Consumer Assessment of Health Plans Survey (CAHPS®) Results for Oklahoma Managed Care Medicaid: 1997, 1998, and 1999, 109
Millar JS, McCauley D, Mitchell L, Winston T, Hays C. Immunization Rate Comparison for Oklahoma Medicaid Managed Care Population by Age Two: 1995-1998, 20
Mitchell L. see Millar JS
Mohon MA. Do Physicians Counsel Smokers to Quit? 103
Montgomery J, Pearson K, Thomas W, Rhoades E, Lorenz D. Folic Acid Knowledge and Multivitamin Use Among Oklahoma Women, 256
Mullins JB. see Flournoy DJ

N

Nair AK, Brandt EN. Effects of Smoking on Health Care Costs, 245
Nixon SJ. see Trautman RP

O

Odutola T, Brandt EN. Violence in Adolescents: Leading Factors, Their Effects, and Possible Prevention, 522
Oklahoma State Board of Health. State of the State's Health, 161
Owen W. see Seradge H

P

Pappas N. see Larson G
Parks S, Paul DW. Ozone Exposure: A Case Report and Discussion, 48
Patrick P. see Byerly P
Paul DW. see Parks S
Pearson K. see Montgomery J
Perdue JJ. see Kojouri K
Phillips ME. see Trautman RP
Pitts K. see Haines JD

R

Rayan GM. see Kagel EM
Rettig SS, Stull TL. Caring for Oklahoma's Children: The Department of Pediatrics and Children's Hospital of Oklahoma, 489
Rhoades E. see Mantgomery J
Radine S. see Lanphier M

S

Saadah HA. Thoughts Upon Joy, 578
Schleifer R. see Vannatta JB
Scoggins L. AMA Litigation Center Pushes for Physician Rights, 68
Scoggins L. American Society of Medical Association Counsel Addresses OIG Draft Compliance Guidance, Litigation Against MCOs, 461
Seba M. Uniform Credentialing Application–Here At Last!, 132
Seradge A. see Seradge H
Seradge H, Baer C, Bithell D. Preventing Carpal Tunnel Syndrome and Cumulative Trauma Disorder: Effect of Carpal Tunnel Decompression Exercises: An Oklahoma Experience, 150
Seradge H, Tian W, Kashef GH, Seradge A, Owen W. The Oklahoma Repair Technique: A Biomechanical Study of a New Suture Repair Technique, 551
Silva FG. see Southmayd L
Sivaram CA. see Kida M
Smith-Edwards C. see Brown S
Southmayd L, Eaton G, Kaufman C, Silva FG. A Cardiac Patient with Renal Failure: A Clinicopathologic Correlation Conference from the University of Oklahoma College of Medicine, 11
Stafford J. Rural Hospitals Provide Much-Needed Patient Care, 148
Stafford J. Physicians Face Challenges in the Practice of Rural Medicine, 143
Stull TL. see Rettig SS

T

Tian W. see Seradge H
Tivis LJ, Brandt EN. Alcohol Consumption Among the Elderly: Dispelling the Myths, 275
Thomas W. see Montgomery J
Trautman RP, Phillips ME, Hallford G, Borrell GK, Nixon SJ. An Overview of Women Seeking Substance Abuse Treatment in Oklahoma, 437

V

Vannatta JB. A History of the University of Oklahoma College of Medicine: Perspectives on Funding the Educational Mission, 475
Vannatta JB, Schleifer R. A Curriculum for Stimulating the Moral Imagination, 63

W

Walter M. see Kida M
Weedn RJ. OSMA Launches Physicians' Campaign for a Healthier Oklahoma, 7
Winston T. see Millar JS

Y

Yarbaraugh WH. Drug Seeking Behavior–A Differential Approach, 242

In Memoriam

1999

Beverly Colvin Chatham, MD December 2
Norman A. Cotner, MD December 3
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Wilson David Steen, PhD December 12
James Thermon McInnis, MD December 18
Douglas Lyons Polk, MD December 19
Thomas S. Llewellyn, III, MD December 26
John Preston McDaniel, MD December 27
Joe Earle Tyler, MD December 31

2000

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Donald Charles Barney, MD January 4
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Richard E. McDowell, MD January 17
Wilson E. Roark, MD January 28
Orval L. Parsons, MD January 29
James William White, MD February 1
Harry L. Deupree, MD February 3
James L. Nicholson, MD. February 3
Leo Meece, MD February 5
Homer A. Ruprecht, MD February 6
William G. McCreight, Sr., MD March 10
Armond H. Start, MD March 30
Billy E. Blevins, MD April 3
Willis E. Lemon, MD April 21
Roy A. Lawson, MD April 22
Benjamin F. Gorrell, MD April 29
Adolph N. Vammen, MD May 8
Joseph D. Weedn, MD May 14
Ross P. Demas, MD May 15
William C. Stone, MD May 18
Hubert M. Anderson, MD May 22
Jack G. Glasgow, MD June 7
Camp S. Huntington, MD July 29
Everett L. Wiggins, MD September 10
Hans Peter Franz Norberg, MD October 6
John F. Gray, Jr., MD October 19
Jerry Hordinsky, MD October 20
George R. Smith, Jr., MD October 23
Arthur Elliot, MD October 24
Joe E. Collins, MD October 25
Helen Ruth Mershon, MD October 26
Francis W. Hollingsworth, MD November 1
Safety R. First, MD November 4
Charles L. Cooper, MD November 13
John W. Records, MD November 29

Obituaries

George R. Smith, Jr., MD
1925-2000

George R. Smith, Jr., MD, died October 23, 2000. Born August 27, 1925, in Goose Creek (now Baytown), Texas, Dr. Smith received his medical degree from Baylor University College of Medicine in 1952. He was a past president of the Oklahoma State Board of Medical Examiners, the Oklahoma chapter of the American Heart Association, and a life member of the Oklahoma State Medical Association since 1998.

Joe E. Collins, MD
1924-2000

Joe E. Collins, MD, died October 25, 2000. Dr. Collins was born December 4, 1924, outside Vinita; he served in the United States Navy during World War II and with the 45th Infantry in Korea. Dr. Collins received his medical degree from the University of Oklahoma School of Medicine in 1948, and was a life member of the Oklahoma State Medical Association since 1989.

Helen Ruth Mershon, MD
1924-2000

Helen Ruth Mershon, MD, died October 26, 2000. Dr. Mershon was born in Pushmataha County on August 21, 1924, and received her medical degree from the University of Oklahoma School of Medicine in 1949. She was named a life member of the Oklahoma State Medical Association in 1998.

Francis W. Hollingsworth, MD
1919-2000

Francis W. Hollingsworth, MD, died November 1, 2000. Born in Oklahoma City on October 31, 1919, Dr. Hollingsworth received his medical degree from the University of Oklahoma School of Medicine in 1944 and served in the United States Army from 1945 to 1947. Dr. Hollingsworth was a member of and chaired the Physician Manpower Training Commission of Oklahoma; he also served as a Trustee to and was a life member of the Oklahoma State Medical Association.

Obituaries (continued)

Safety R. First, MD
1920-2000

Safety R. First, MD, died November 4, 2000. Born March 6, 1920, in Barnsdall, Dr. First received his medical degree from the University of Oklahoma School of Medicine in 1943. Dr. First was a life member of the Oklahoma State Medical Association since 1986.

Charles L. Cooper, MD
1939-2000

Charles L. Cooper, MD, died November 13, 2000. Born June 5, 1939, in Brooklyn, New York, Dr. Cooper received his medical degree from the University of Chicago in 1964 and served active military duty in the United States Air Force from 1969 to 1971. Dr. Cooper served as president of both the Tulsa chapter and the Oklahoma chapter of the American Heart Association, and was a member of the Oklahoma State Medical Association.

John W. Records, MD
1911-2000

John W. Records, MD, died November 29, 2000. Born February 10, 1911, in Kansas City, Missouri, Dr. Records received his medical degree from Washington University in 1936. He served five years in the United States Army, holding the rank of Lieutenant Colonel at the time of his discharge. Dr. Records was a life member of the Oklahoma State Medical Association.

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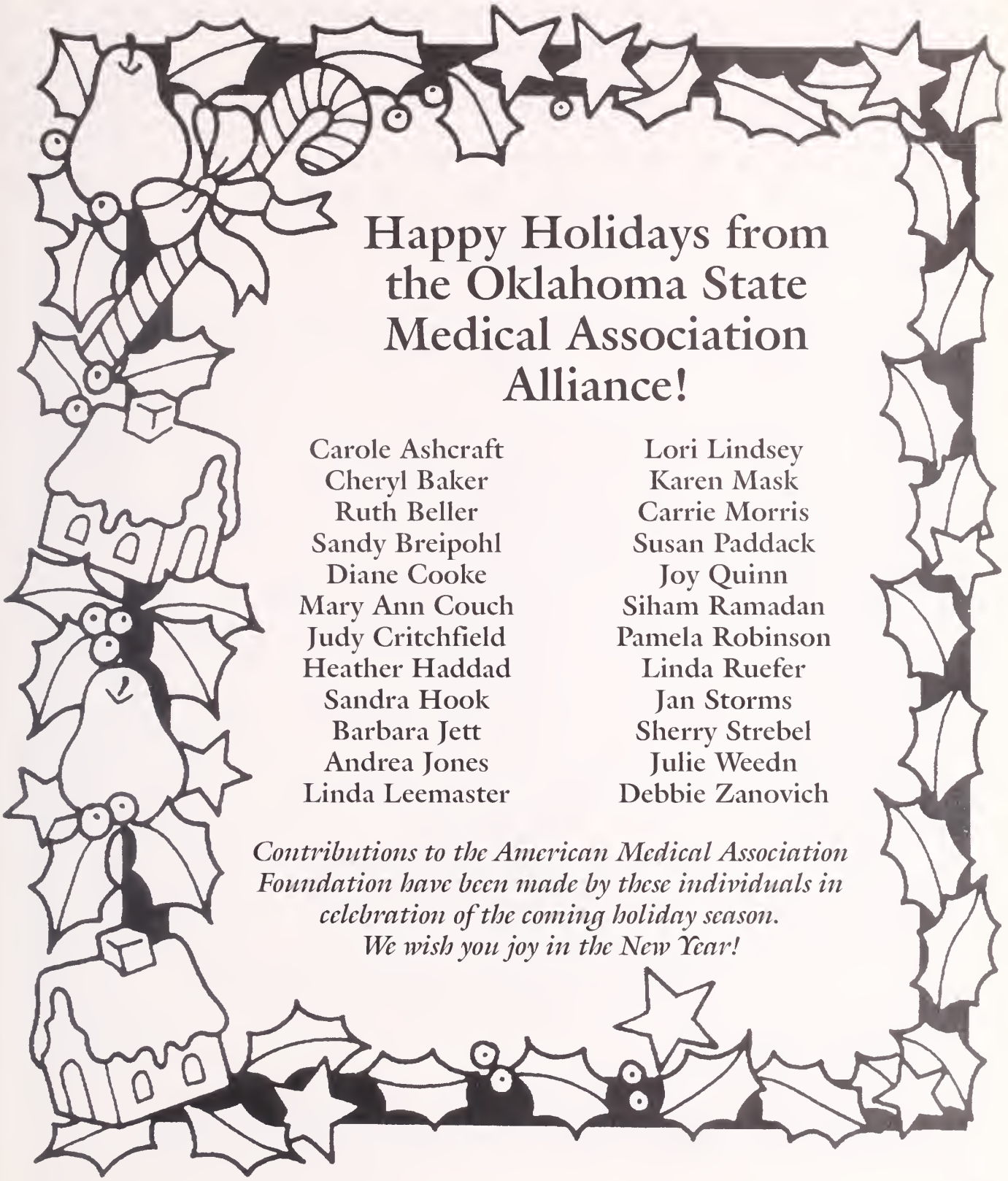
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Course offerings from OSMA-Accredited Institutions

Deaconess Hospital: Yvonne Curtright 405/604-4979

Dec. 7	Cancer Conference	12:15 pm	1 hour
Dec. 14	Cancer Conference	12:15 pm	1 hour
Dec. 21	Cancer Conference	12:15 pm	1 hour
Dec. 28	Cancer Conference	12:15 pm	1 hour

Hillcrest Medical Center: Linda Gondles 918/579-5235

Dec. 1	HIPAA Medical/Legal Compliance	12 noon	1 hour
Dec. 8	Asthma Update	12 noon	1 hour
Dec. 15	"Thromboembolic Tx & Prophylaxis"	12 noon	1 hour

Integris Southwest Medical Center: Jonathan Stotler 405/636-7087

Dec. 5	Prospective Breast Care Conference	12:15 pm	1 hour
Dec. 6	Disorders of the Prostate	12:15 pm	1 hour
Dec. 7	Cancer Conference	12:15 pm	1 hour
Dec. 13	"Asthma"	12:15 pm	1 hour
Dec. 14	Cancer Conference	12:15 pm	1 hour
Dec. 19	Prospective Breast Care Conference	12:15 pm	1 hour
Dec. 20	"Lymphedema"	12:15 pm	1 hour
Dec. 21	Cancer Conference	12:15 pm	1 hour

Mercy Health Center: Debbie Stanilla 405/752-3806

Dec. 5	Multidisciplinary Breast Conference: "Breast Cancer Prevention"	7:00 am	1 hour
Dec. 7	"Living with Dying" Dr. Bill Bartholome	12:15 pm	1 hour
Dec. 13	Tumor Board: "Adjuvant Therapy of Melanoma"	7:00 am	1 hour
Dec. 14	"Adult Immunizations"	12:15 pm	1 hour

St. John Medical Center: Gail Hilst 918/744-2875

Dec. 5	Critical Care Conf.: "Lower GI Bleed"	12 noon	1 hour
Dec. 7	Critical Care Conf.: "Atrial Arrhythmias"	12 noon	1 hour
Dec. 19	Critical Care Conf.: "Carbon Monoxide Poisoning"	12 noon	1 hour

University of Oklahoma Health Sciences Center: 405/271-2350

Dec. 2	Spinal Instrumentation Workshop #1068	3.5 hours

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator, at 405/843-9571 or 800/522-9452.

Oklahoma State Medical Association

Continuing Medical Education

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Norman Regional Hospital
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Orthopaedic & Reconstructive Research Foundation
Oklahoma City

St. Anthony Hospital
Oklahoma City

Saint Francis Hospital
Tulsa

St. John Medical Center
Tulsa

Shawnee Regional Hospital
Shawnee

Stillwater Medical Center
Stillwater

Valley View Hospital
Ada

Course offerings from OSMA-Accredited Institutions

Deaconess Hospital: Yvonne Curtright 405/604-4979

Jan. 4, 11, 18, 25	Cancer Conference	12:15 pm	1 hour
15	"Legal Issues Regarding Medical Office"	6:30 pm	1 hour
15	"Physician Handwriting"	8:00 pm	1 hour

Integris Baptist Medical Center: Donna Schoenfelder/Jean Middleton 405/949-3284

Jan 5	Tumor Board	7:00 am	1 hour
8	Medicine Department	7:00 am	1 hour
8	"Practical Guidelines for Prevention & Treatment of Thromboembolism"		
10	Dental Department	7:00 am	1 hour
12	Cancer Conference	7:00 am	1 hour
16	Family Practice	7:00 am	1 hour
16	"Standards for Diabetes Care 2000"		
19	Tumor Board	7:00 am	1 hour
19	OB/GYN Department	7:00 am	1 hour

Integris Southwest Medical Center: Jonathan Stotler 405/636-7087

Jan. 3	Cholesterol/Lipids	12:15 pm	1 hour
4, 11, 18, 25	Cancer Conference	12:15 pm	1 hour
10	Prevention and Treatment of Thromboembolism	12:15 pm	1 hour
2, 16	Breast Care Conference	12:15 pm	1 hour
17	Pneumonia Pharmacotx	12:15 pm	1 hour
24	Anxiety Disorder	12:15 pm	1 hour
31	Hospice	12:15 pm	1 hour

Integris Bass Baptist Health Center: Tracy Bittle 358/548-1247

Jan. 25	"Role of Anticoagulation in Acute Coronary Events"	12:15 pm	1 hour

Mercy Health Center: Debbie Stanilla 405/752-3806

Jan. 11	Treatment of Epilepsy	12:15 pm	1 hour
18	Thrombosis Research	12:15 pm	1 hour
25	Breast Cancer Treatment Options	12:15 pm	1 hour
24	Ethics For Lunch: "Know Your Neighbor Series"	12:00 noon	1 hour

St. John Medical Center: Gail Hilst 918/744-2875

Jan. 9	Critical Care Conf.: "Thyroid Disease"	12 noon	1 hour
11	Critical Care Conf.: "Evaluation of Shock"	12 noon	1 hour
18	Critical Care Conf.: "Medical Ethics"	12 noon	1 hour
23	Nosocomial & Ventilator Associated Pneumonia	12 noon	1 hour
25	Interventional Radiology	12 noon	1 hour
30	Superior Vena Cave Syndrome	12 noon	1 hour

For information regarding a listed course, call the appropriate contact. For information regarding CME requirements or becoming an accredited provider, call Barbara Matthews, OSMA CME Coordinator, at 405/843-9571 or 800/522-9452.

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THE LAST WORD

AMA Congratulates President-elect Bush, Looks Forward to Addressing Key Health Issues

On Thursday, December 14, the American Medical Association congratulated President-elect George W. Bush and said it looked forward to working with the Bush Administration and the new Congress on key health issues including patients' rights, the uninsured, Medicare reform, and antitrust reform. AMA President Randolph D. Smoak, Jr., MD, emphasized the AMA's commitment toward enacting a strong patients' bill of rights and noted that President-elect Bush has praised a Texas law that enables patients to hold health plans accountable for their decisions. Dr. Smoak also expressed a need to address America's uninsured, explaining that the AMA's proposal for a system of tax credits for the uninsured, when combined with full enrollment of all those eligible for Medicaid and the Children's Health Insurance Program, would bring the United States "very close" to the goal of health insurance for all Americans.

Distorted Images of Females Dominate Top-Selling Video Games

New research from Children Now, a California-based children's advocacy organization, indicates that violent, sexually provocative, and stereotypical female images dominate almost half of the top-selling video games. In their analysis of the top-ten selling video games for Sony PlayStation, Sega Dreamcast, and Nintendo 64, the group found that of games containing female characters:

- 38% displayed characters with significant body exposure, including 23% with exposed breasts or cleavage, 31% with exposed thighs, 15% with exposed derrieres, and 31% with exposed midriffs;
- 38% of female game characters had "large" breasts and 46% had "unusually small" waists; and
- 54% involved female characters "fighting" or "being violent."

Of the findings, Lois Salisbury, Children Now president, says, "The unhealthy messages that both girls and boys absorb from these new media impact the way they think girls are supposed to look and act." The research found positive examples for girls, including "Mia Hamm Soccer," "You Can Be a Woman Engineer," and "Rugrats: Time Travelers."

THE ACADEMY OF MEDICINE
JAN 17 2001

Oklahoma Leads Nation in Increases in Medicaid Coverage

A recent report issued by the Kaiser Commission on Medicaid and the Uninsured, a philanthropic group that deals with national health issues, has indicated that Oklahoma has increased the number of uninsured children covered by Medicaid to more than any other state in the nation. Oklahoma increased the number of children covered by Medicaid by 39.1% during a 31-month period from June 1997 to December 199. This increase was the highest in the nation, and higher than the percentage increases for Kansas, New Mexico, Colorado, Texas, and Arkansas combined.

American Cancer Society Accepting Automobile Donations

The American Cancer Society (ACS) is currently accepting automobile donations as part of its "Auto Auction" program. The Auto Auction is a fundraising program through which automobiles are donated to the American Cancer Society and then auctioned; proceeds from each auctioned automobile are used to help fund cancer-fighting programs. An appropriate tax deduction may be taken for the donated automobile. To donate your vehicle to the American Cancer Society's Auto Auction program, call 800/733-9888, and ACS will make arrangements to have someone pick up your donated vehicle.

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